MEDIGAP: ISSUES AND UPDATE 1982

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1982

INTERGOVERNMENTAL
HEALTH POLICY PROJECT
The George Washington University

The research for this report was funded principally by the Office of Research and Demonstrations (ORD), Health Care Financing Administration, Department of Health and Human Services, through HCFA Grant 18-P-97321/3-03. The interpretations and conclusions are those of the authors and should not be attributed to the Intergovernmental Health Policy Project or the Department of Health and Human Services.

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MEDIGAP:
ISSUES AND UPDATE

Edited by:

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June, 1982

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Intergovernmental Health Policy Project
1919 Pennsylvania Ave., N.W.
Suite 505
Washington, D.C. 20006

List price: $7.00

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TABLE OF CONTENTS

Foreword i

Acknowledgements iii

Chapter I Introduction 1

Chapter II The Elderly, Medicare and Private Health Insurance 5

Chapter III Current Issues in the Implementation of the Federal Voluntary Certification Program

A. The Department's View 17
As represented by the Health Care Financing Administration, Department of Health and Human Services

B. The Congressional View 21
As represented by Senator Max Baucus (D-Montana)

C. The State Insurance Regulators' View 27
As represented by the National Association of Insurance Commissioners

D. The Consumers' View 43
As represented by the National Retired Teachers Association and American Association of Retired Persons

E. The Health Insurers' View 51
As Represented by the Blue Cross/Blue Shield Association

F. The Health Insurers' View 57
As Represented by the Health Insurance Association of America

Chapter IV Summaries of State Regulation of Medicare Supplements 61

Chapter V Summary Table of Specific State Laws and Regulations Governing Medigap Policies 91

Appendix The Supplemental Health Insurance Panel's Report to the Committee on Finance of the Senate, and to the Committees on Energy and Commerce and Ways and Means of the House of Representatives

FOREWORD

In October 1979 the Intergovernmental Health Policy Project published *Medigap: State Responses to Problems with Health Insurance for the Elderly.* The report, authored by T. Van Ellet, provides an excellent resource for those wishing to understand the nature and extent of state legislative and regulatory actions governing the sale of Medicare supplement health insurance (Medigap) policies just prior to the emergence of Medigap as a major national concern.

The report noted that by mid-1979 only a handful of states, chiefly California and Wisconsin, had taken comprehensive steps to curb growing abuses in the promotion and sale of Medigap policies. Several other states were indeed aware of the increasing problems and abuses but as yet had adopted only limited measures to control them. The majority of states at that time, however, either did not perceive the Medigap issue as a serious problem or felt that their existing insurance statutes and regulations were adequate to deal with any problems that might arise.

Two significant events occurred in 1979 and 1980 which gave rise to the need for an update of the previous study. The first event was the promulgation by the National Association of Insurance Commissioners of model state regulations governing Medicare supplements; the second was the adoption in 1980 by the U.S. Congress of the Baucus Amendment creating a Voluntary Certification Program for Medicare supplemental health insurance policies.

The format of the 1982 update is decidedly different from the 1979 version. In addition to a state-by-state summary of legislative and regulatory actions adopted in response to the NAIC recommendations or the Baucus Amendment, this report includes an examination of a number of key policy issues and questions surrounding the development and implementation of the federal Voluntary Certification Program from the points of view of several diversely affected parties. This new section includes the perspectives of Congress, consumers, state insurance regulators, and the insurance industry. Each of the organizations representating these interests was asked to address the following issues:

1) The need for regulation of the supplemental health insurance market for the elderly and the viability of the Voluntary Certification Program as as appropriate response to the perceived deficiencies in that market;

2) The strengths, weaknesses and problems of the Voluntary Certification Program from the standpoint of: a) the use of loss ratios to measure policy worth; b) the applicability of the program to all Medicare eligibles or just those 65 and older; c) the use of minimum NAIC standards and the differences between those standards and the Medicare program; and d) the role of the Supplemental Health Insurance Panel;

3) The likely impact of the Voluntary Certification Program on consumers, insurers and regulators; and

4) The probable future of the Voluntary Certification Program and an assessment of where future regulatory authority over the supplemental health insurance market for the elderly should reside.

This Medigap report is an outgrowth of the overall mission of the Intergovernmental Health Policy Project to share important state practices and innovations as a focus for future discussion, analysis and problem solving. It is our hope that this update will be a useful resource for state and federal policymakers whose concern it is to ensure that certain basic standards in the promotion and sale of Medicare supplemental policies are upheld.

Richard E. Merritt

ACKNOWLEDGEMENTS

Credit for the genesis of this publication goes to T. Van Ellet, the author of the 1979 IHPP book entitled, *Medigap: State Responses to Problems with Health Insurance for the Elderly.* His foresight and perseverance were critical to the achievement of an update of the earlier volume.

Special thanks go to Donna Potemken, Research Assistant with IHPP, who was principally responsible for the completion of the publication. Donna was responsible for the important interviews of the state insurance departments, for the research and writing of the updates of the state regulatory activities and for providing the summary tables on state Medigap actions. Donna also provided considerable assistance in editing and organizing other portions of the book.

One of the essential features of this publication is the chapter on "Issues in the Implementation of the Federal Voluntary Certification Program." This chapter would not have been possible without the full cooperation of the various organizations which agreed to submit their views and comments. Special appreciation must go to the following individuals who were chiefly responsible for responding on behalf of their respective organizations: David Brummond (National Association of Insurance Commissioners); Ron Hagen (National Retired Teachers Association/American Association of Retired Persons); Alan Richards (Blue Cross/Blue Shield Association); Rita Theisen and Geza Kadar, Jr., (Health Insurance Association of America); Deborah Landau (Office of Senator Max Baucus); and Bob Silva and Toba Winston (Health Care Financing Administration), as well as the HCFA Medigap Operations Staff.

Finally, a special note of thanks goes to the state insurance commissioners and their staffs for their cooperation and the generous amount of time they devoted to responding to our inquiries for information.

Richard E. Merritt
Director
Intergovernmental Health Policy Project

CHAPTER I

Introduction

INTRODUCTION

By T. Van Ellet and Richard E. Merritt

The rising cost of medical care creates enormous problems for both health care providers and consumers. No segment of the population, however, is more adversely affected by pervasive and persistent inflationary pressures than the elderly.

Although the aged represent about 11 percent of the population, they account for over 29 percent of all personal health expenditures.[1] Today public funds cover almost two-thirds of the health care costs of the elderly, whereas they accounted for slightly less than one-third in 1966 when the two programs began.[2] Medicare alone provides an estimated 44 percent of the total health expenditures of the elderly, up from 39 percent in 1970.[3] Nevertheless, according to a recent analysis performed by the staff of the Senate Special Committee on Aging, "Total per capita health care costs not paid for by Medicare have also grown as a percentage of the elderly's income over the past decade, from 16.8 percent of total income in 1970 to 19.1 percent in 1980, to the point where such expenses now approach pre-Medicare levels (20.4 percent)".[4] In addition, over the past several years, the proportion of the elderly's total health care expenditures derived from direct out-of-pocket payments has remained at around 29 to 30 percent.[5]

While Medicare has contributed generously to the coverage of health care expenses for the elderly, it was never designed as a comprehensive program. Instead, Medicare was intended to function as a core health insurance program, providing payments chiefly for acute care services. The elderly poor were expected to obtain expanded coverage with the assistance of Medicaid, while the elderly non-poor could augment their coverage by purchasing private health insurance. Currently, more than 70 percent of the elderly have some kind of supplemental assistance, either through the private health insurance market or Medicaid.

The private health insurance industry has been very successful in designing and marketing policies which supplement the coverage provided by Medicare. The acknowledged need for these policies has been fostered by a number of factors, especially the complex and often inadequate benefit structure of the Medicare program itself. Confused by the gaps in Medicare coverage and fearful of the financial hardships of poor health, the elderly have turned in increasing numbers to private health insurance for protection. In 1979, approximately 64 percent of the aged bought private hospital insurance, while 43 percent purchased private surgical insurance.[6] It is the problems surrounding the sale of Medicare supplements and other forms of private health insurance to the elderly that are commonly commonly referred to as the "Medigap" issue.

The tremendous growth in the Medigap industry, coupled with an increasing number of allegations of abuses in the system, led to increased public concern and scrutiny. Congressional hearings conducted in 1978 produced substantial evidence that a significant and growing portion of the elderly were being taken advantage of in the purchase of Medicare supplemental policies. Testimony revealed that a small segment of the insurance industry was exploiting the needs and fears of the elderly and the rather unrestricted nature of the supplemental insurance

marketplace. Specific testimony pointed to such abusive practices as the sale of duplicate policies; the sale of policies with "fine print" provisions precluding benefit payments for a broad range of illnesses; and the misrepresentation by some insurers as being a government representative. Government estimates in 1978 projected that as much as 23 percent of those purchasing Medicare supplements had some degree of unnecessary insurance coverage.[7]

While at the same time Congressional interest in the Medigap problem was growing, several states were at work examining their existing regulations, identifying weaknesses and proposing changes where needed. In early 1978 both Wisconsin and California implemented a number of comprehensive reforms in the sale of private health insurance to the elderly. Wisconsin's new regulations, for example, called for the creation of four clearly defined categories of Medicare supplement insurance and minimum levels of coverage for each category. The regulations also included very extensive disclosure requirements and consumer information assistance. Public hearings were underway in several other state legislatures, many of which led to improvements in existing laws or the addition of new legislation or regulations. Also of great significance was the appointment of a special task force in 1978 by the National Association of Insurance Commissioners to examine the broad issue of marketing private health insurance to the elderly. The study resulted in the promulgation of a set of model state regulations governing Medicare supplements. The model regulations included such provisions as:

- policy restrictions no more restrictive than those used in the Medicare program;
- prohibition of specifically defined preexisting condition limitations in Medicare supplement policies;
- prohibition of preexisting condition limitations longer than six months for conditions for which medical advice was given within six months before the effective date of coverage;
- a recommended 60 percent loss ratio benchmark to prevent excessive rates;
- automatic coordination with Medicare deductible and copayment percentage factors;
- prohibition of the use of "Medicare Supplement," "Medigap," or words of similar import unless policies meet the minimum standards for such policies;
- minimum benefits standards for Medicare supplement policies filling out coverage of all eligible expenses for the 61st through the 90th day under Part A of Medicare; coverage of the daily hospital charges incurred during use of the Part A lifetime reserve; after exhaustion of the lifetime reserve, coverage of 90 percent of all Medicare Part A eligible expenses for an additional 365 days; and coverage of the 20 percent of Medicare eligible expenses under Part B subject to a private policy deductible and maximum benefit of a least specified amount;
- full and fair disclosure of benefits, exclusions, and limitations in a specified outline of coverage form;
- delivery of a uniform buyers' guide; and
- a 30-day "free look" provision.

However, in spite of enhanced state attention and action, boosted to a considerable degree by NAIC's model standards, the perception remained at the

federal level that the states' responses were for the most part inadequate and insufficient in meeting the myriad problems arising out of the sale of Medicare supplement policies. Specifically, the final report of the House Select Committee on Aging concluded that "enacted regulations have not been enforced and that most states are not doing an adequate job protecting senior citizens against those unscrupulous companies and agents which would seek to take advantage of them...Enforcement efforts at the state level must be greatly strengthened..."[8] The report went on to assert that since "states have not taken strong measures, individually and as a whole, the federal government must step in to protect the nation's senior citizens from further abuse."[9]

Less than two years later the U.S. Congress followed through on some of the Select Committee's conclusions by accepting a limited federal presence in and responsibility for the marketing of Medigap policies. With the enactment of the Voluntary Certification Program (section 507 of PL 96-265, otherwise known as the Baucus Amendment after Senator Max Baucus of Montana, the legislation's original sponsor) Congress created an incentive for the states to upgrade their regulation of Medicare supplement health insurance policies.

The legislation clearly reflected considerable deference to the traditional state governmental role in the regulation of insurance. Nevertheless, Congress's intent was to precipitate immediate and uniform action on the part of the states through a "carrot and stick" approach. States that were willing to establish and enforce minimum regulatory standards governing Medigap policies would be free of any federal intervention. However, an alternative certification program administered at the federal level would apply to policies issued in states that chose not to adopt the minimum standards by July 1, 1982. Determinations as to whether a state's regulatory program meets these standards would be made by a Supplemental Health Insurance Panel, appointed by the President. The Panel would consist of four state insurance commissioners and would be chaired by the Secretary of the Department of Health and Human Services. The law required the Secretary to submit to the appropriate Congressional committees by January 1, 1982, a report identifying those states that the Panel determined cannot be expected to implement a satisfactory program by the July 1 deadline. The law further required the Secretary to submit a report on July 1, 1982, and every two years thereafter, evaluating the effectiveness of the Voluntary Certification Program.

INTRODUCTION

[1] Charles R. Fisher, "Differences by Age Groups in Health Care Spending," *Health Care Financing Review,* Spring 1980, p. 65.

[2] *Developments in Aging: 1981,* A Report of the Special Committee on Aging, United States Senate, 97th Congress, 2nd Session, Report 97-314, March 1982, P. 295.

[3] Fisher, p. 76.

[4] "Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide?" (An Information Paper prepared by the staff of the Special Committee on Aging, United States Senate). Committee Print 92-225, April 1982, P. III.

[5] *Ibid.*

[6] Marjorie Smith Carroll and Ross H. Arnett, III, "Private Health Insurance Plans in 1978 and 1979: A Review of Coverage, Enrollment, and Financial Experience." *Health Care Financing Review,* September 1981, p. 55.

[7] U.S. Congress, House Select Commitee on Aging, Prepared Statement by Elizabeth Hanford Dole, Commissioner, Federal Trade Commission, *Abuses in the Sale of Health Insurance to the Elderly,* Hearing before the Select Committee on Aging, 95th Congress, 2nd Session, 1979, p. 141.

[8] U.S. Congress, House Select Committee on Aging, "Abuses in the Sale of Health Insurance to the Elderly," p. 327.

[9] *Ibid.*, p. 319.

CHAPTER II

The Elderly, Medicare and Private Health Insurance

THE ELDERLY, MEDICARE, AND PRIVATE HEALTH INSURANCE

by
T. Van Ellet

MEDICARE AND THE ELDERLY

Since the structure of the Medicare program has contributed significantly to what has become known as the "Medigap" problem, any explanation of Medigap abuses must start with a look at Medicare. This federal insurance program consists of two parts. Part A, the Hospital Insurance component, helps the elderly pay for inpatient hospital care, for a limited amount of care in a skilled nursing facility (SNF) certified by the Medicare program, and for some forms of home health care. Part B, the Supplementary Medical Insurance Program, helps pay for physicians fees and for some outpatient and other nonhospital services. Almost all (97 percent) of the nation's senior citizens are covered by the Hospital Insurance Program, while a slightly smaller number (95 percent) elect to participate in the voluntary Part B program.[1] Parts A and B both contain certain cost-sharing provisions such as deductibles and coinsurance payments. Table II at the end of this chapter summarizes the costs and benefits of both programs.

Medicare has been a valuable resource for the nation's elderly, particularly because they require more medical care than other age groups. For example, the National Center for Health Statistics reported that in 1979 the hospitalization rate of persons 65 and over was two and one-half times that of those under 65. Also, their average length of stay in a hospital is almost two times that of other age groups. Moreover, persons 65-plus account for 25 percent of total hospital stays.[2]

Despite increased federal spending for both Medicare and Medicaid, a growing number of senior citizens have found the insurance program flawed and inadequate and, as a result, have turned to private health insurance for protection. Several reasons explain the attraction of private health insurance to the elderly. For example, they now must pay an increasing portion of their limited incomes to participate in the Medicare program. In addition, with the rapid, excessive growth in the cost of medical care, Medicare covers less and less of the elderly's total health bill. Finally, medical services reimbursed by Medicare are limited and leave many significant gaps in coverage. Medicare is geared more toward episodic, short-term, acute illnesses rather than the chronic, long-term disorders prevalent in the elderly population. Therefore, many of the greatest needs of the elderly, such as custodial, dental , and eye care, are not covered at all. The following sections briefly elaborate on some of the many deficiencies in the Medicare program.

Increasing Cost-Sharing Provisions

The Social Security Act mandates that Medicare cost-sharing requirements be adjusted annually to help offset the increased costs of providing medical care. The use of these cost-sharing requirements is believed necessary to prevent overutilization of the health care system and to protect the fiscal integrity of the

Medicare program. However, such requirements have risen much faster than the cost-of-living increases provided to the elderly by the Social Security program. Table I summarizes some of the increasing costs of the Medicare program.

TABLE I

Medicare Premium Costs, Deductibles and Co-Insurance Rates (1966, 1981 and 1982)

Cost Sharing Requirement	1966	1981	1982
Hospital Insurance Deductible (Part A)	$40	$204	$260
Monthly Premium[1] (Part A)	NA	$89	$113
Hospital Co-Insurance 61st-90th Day)	$10/day	$51/day	$65/day
Co-Insurance (60 "Lifetime" Reserve Days)	$20/day	$102/day	$130/day
Co-Insurance (21st-100th Day, SNF Care)	$5/day	$25.50/day	$32.50/day
Medical Insurance Premium (Part B)	$3/mo.[2]	$11/mo.[2]	$12.20/mo.[2]
Medical Insurance Deductible (Part B)	NA	$60	$75[3]

[1] For those 65 or older who are not eligible for Social Security benefits.
[2] Effective July 1 of calendar year.
[3] First increase since 1973.

The above figures demonstrate the eroding medical purchasing power of the elderly. Part A deductibles have risen from $40 in 1966 to $260 in 1982, a 550 percent increase. Since coinsurance rates are computed from and based on the deductible figure, they have also risen 550 percent during the same period. As for Part B, the Medical Insurance portion of the program, premium costs are $12.20 a month as of July 1982. This is a 307 percent increase from the $3.00 in 1966. Finally, the Medicare Part B annual deductible was increased to $75—the first increase in nine years.

These statistics must be considered in relation to the cash benefits afforded to senior citizens by the Social Security Program. In 1965 the average cash benefit for retired workers was $84 a month. This figure rose to $318 in July 1979, a 278 percent increase.[3]

Rising Cost of Medical Care

The problems faced by the elderly in paying for medical care are severely compounded by the fact that the cost of health services is rising far faster than that of most other portions of the economy. In 1966 the average cost of treating an elderly patient was $445. This figure rose to $2,640 in 1980, a 490 percent increase.[4] The average medical care bill for the aged has been more than two and one-half times the bill for those 19-64 and almost seven times the average bill for those under 19.[5] In 1980, per capita expenditures were approximately $308 for hospital services for the under-65 population and $1,087 for those 65 and older.[6] Because 29 percent of the elderly's medical expenses are paid directly by the patients, these increasing costs are exceptionally hard on them. In 1977, the elderly paid an average of $90 per capita for private health insurance premiums, plus another $78 per capita for Supplementary Medical Insurance premiums. Those 65 and older paid an average of almost $700 for health related services and items out-of-pocket—amounting to 12 percent of their average income.[7] In 1980 the average senior citizen's out-of-pocket medical bill was $760, more than three times the average bill paid by those under 65.[8]

One reason the elderly pay more out-of-pocket is that fewer physicians are agreeing to accept full payment from Medicare for their services, or "assignment" as it is commonly known. When a physician does not accept assignment, the elderly patient is responsible for the difference between what Medicare will pay and what the doctor charges for a particular service. In 1978, 50.6 percent of all physicians accepted assignment, compared with a high of 61.5 percent in 1969.[9] The decrease in physician participation undoubtedly means more senior citizens are paying a greater portion of their medical expenses than ever before.

Medicare Benefits and Limits

As mentioned earlier, Medicare was not designed to meet or to pay for all of the health needs of the elderly. Some of the program's most significant limitations are summarized below.

1. *Cost-Sharing Provisions*—Under Part A, hospital insurance, the patient pays an initial deductible of $260 for each benefit period entailing hospital care. From the 61st to the 90th day, the patient must pay $65 for each day of care; from the 91st to the 150th day the patient pays $130.

Under Part B, medical insurance, the patient pays monthly premiums of $12.20. After paying a deductible of the first $60 of "reasonable charges" for covered medical expenses in each calendar year, the patient is also responsible for 20 percent of the charges for any additional services covered by Medicare.

2. *Lifetime Reserve Days*—After the 90th day of hospitalization, patients start using their 60 lifetime reserve days of hospital care. Once these reserve days are expended (they can only be used once), Medicare Part A coverage ends. The patient is then responsible for all costs. If poor and unable to pay, the patient can become a Medicaid recipient.

3. *Skilled Nursing Home Care*—Medicare Part A places severe limitations on nursing home care benefits in spite of the acute need for this kind of service. The extent of these limitations is best exemplified by the fact that, although 23 percent of all medical expenses of the elderly go for nursing care, Medicare paid for about

3 percent of these expenses in 1977 (Medicaid paid for 42 percent).[10] About one million senior citizens use nursing homes each year at an average annual cost of $14,600.[11]

The federal government's "Medicare Handbook" lists the following five eligibility requirements for care in a Medicare certified SNF:

- A person must have been in a hospital for at least three days in a row (not counting the day of discharge) before transferring to a participating SNF.
- The patient must be transferred to an SNF to obtain care for a condition which was treated in the hospital.
- A doctor must certify that the patient needs and actually receives skilled nursing or skilled rehabilitation services on a daily basis.
- A patient must be admitted to an SNF within 14 days of leaving the hospital.
- The facility's Utilization Review Committee (URC) or a Professional Standards Review Organization must approve the stay.

Since all five conditions must be met, access to this kind of necessary care is very difficult. There are also some coinsurance payments required by the elderly who obtain care in an SNF. Medicare does pay the entire cost for the first 20 days. From the 21st through the 100th day, however, the patient must pay $32.50 a day. After the 100th day, the patient pays all costs.

4. Custodial Nursing Home Care—Despite the fact that most senior citizens require custodial (not skilled) nursing care, Medicare only pays for care received in a skilled nursing facility.

5. Psychiatric Inpatient Care—Part A of Medicare pays for no more than 190 days of psychiatric inpatient care in a person's lifetime.

6. Home Health Care—The restrictions on home health services are very similar to those governing skilled nursing care. Medicare Part A pays for up to 100 home health visits in a calendar year. Most of the personal and custodial care services needed by the elderly patient are not covered.

7. Physician Reimbursement—As noted, under Medicaid Part B, physicians, if they accept assignment, are often reimbursed 80 percent of the "reasonable" charges for covered services. Reasonable charge is the lowest of the doctor's charge, the customary charge, or the prevailing charge in the area. If a physician does not accept assignment, and his fee exceeds what Medicare will pay, the patient is responsible for the difference.

8. Services Not Covered—Many important services, often major items for the elderly, are not covered at all by Medicare. Some of these are: out-of-hospital drugs, dental care, eye or hearing examinations, eyeglasses, heaing aids and dentures. According to the Social Security Administration, only 22 percent of older Americans have private health insurance coverage for out-of-hospital prescription drugs; less than 3 percent have any form of dental coverage.[12]

9. Preventive Care—Medicare does not reimburse for any health maintenance or preventive care services such as routine physical examinations, diagnostic tests and immunizations.

PRIVATE HEALTH INSURANCE AND THE ELDERLY

The increasing cost-sharing requirements under Medicare, and the concomitant increases in supplemental health insurance costs, plus reductions in public support for elderly health benefits and the growing reluctance of physicians to accept Medicare assignment are grounds for legitimate concern by the elderly regarding the ability of Medicare to adequately cover their financial needs during times of illness. Despite the fact that private health insurance pays for only a relatively small portion of the elderly's total health bill—less than 7 percent—a growing number of individuals 65 and over are turning to the private health insurance market to augment their Medicare benefits.

Types of Policies Offered to the Elderly

The Medicare supplement or Medigap policies offered by the private health insurance industry are as complex and varied as the benefit structure of the Medicare program itself. Under state law they generally fall into the category of health insurance policies, but they also may be known as accident and health or disability policies. The vast array of Medigap policies and related benefit packages does provide the buyer with significant options in benefits and prices. For many senior citizens, however, such variety only adds to the confusion caused by the complicated structure of Medicare.

Private health insurance policies generally fall into three categories: the Medicare supplement (including major medical), the indemnity, and the limited or dread disease policies. Some of the characteristics of each type follow:

1. *Medicare Supplement Policies*—This kind of policy, generally referred to as "wraparound coverage," is the only health insurance which truly supplements Medicare's benefit structure. Designed to fill the gaps not covered by Medicare, these policies usually pay some or all of Medicare's deductible and coinsurance requirements and a percentage of actual charges unmet by the federal insurance program. Most private health insurers and the Blue Cross plans offer this kind of policy with an almost infinite range of benefit structures and concomitant costs. None of these policies, however, cover physician charges above the rates allowed by Medicare, or services such as routine physicals and custodial care. Many insurance officials feel one good Medicare supplement policy is the best insurance protection for most senior citizens.

2. *Indemnity Policies*—This kind of coverage usually pays a fixed amount for each day of hospitalization. Some policies pay from the very first day of hospitalization, while others do not.

Indemnity policies are attractive to the elderly because they pay in addition to other insurance of the policyholder, providing extra income in times of illness. However, benefits are not structured to reflect the actual charges for an inpatient stay in a hospital. With the average cost of a day of hospital care at $266 in 1981,[13] the usual indemnity benefit of $20 to $50 a day does not provide any real financial protection for the aged patient. Also, considering the fact that in 1979 the average hospital stay for someone over 65 was 11.5 days, the overall payout of an indemnity policy, especially relative to the premium paid, is usually quite limited.

3. *Limited Policies*—Another form of indemnity insurance is the limited or

"dread disease" policy. The most prevalent kind of limited policy is cancer insurance. As the second leading cause of death, cancer poses a special concern to senior citizens. As it is a protracted and expensive illness, the cost of treating a cancer (other than skin cancer) patient exceeds $20,000.[14]

Because most benefits are keyed to hospitalization, limited or dread disease policies do not provide cost-effective insurance protection for senior citizens. The average cancer patient stays in the hospital for seven days and is hospitalized only 1.8 times in a two-year period.[15] As a result, the rate of return to policyholders is so low that only one of six people who contract cancer ever breaks even on the money paid in premiums.[16]

Dread disease policies are the subject of much controversy and concern. In some cases, their fragmented, narrow protection and the low rate of return have made these policies and those companies selling them the target of investigations by regulatory authorities. Connecticut and New Jersey were the first states to prohibit the sale of dread disease policies. Several consumer advocacy groups recommend that senior citizens not purchase limited policies. These groups note that the insurance dollars spent on dread disease policies would provide more protection if invested, or if used to purchase a more comprehensive Medicare supplement policy.

Major Problems and Limitations

Serious problems exist in the private health insurance marketplace, both in terms of the benefits provided to elderly policyholders and the techniques used by some companies and agents to sell such policies. These problems are difficult to document, much less resolve. A series of Congressional hearings in 1978 on Medigap issues, and the report issued by the Federal Trade Commission in July 1978, dealt extensively with problems in the health insurance marketplace. Special attention was given to seemingly widespread agent abuses in the sale of health insurance to the elderly. This section summarizes some of the most pronounced problems and abuses noted by these investigations.

1. Lack of Standardization—One of the basic problems with private health insurance is the lack of policy standardization. Since insurance companies offer an almost unlimited variety of benefit packages, it is virtually impossible for the elderly to select the best, most appropriate kind of coverage.

Some policies provide benefits which cover only Part A or Part B of Medicare. Still others are more comprehensive and extend coverage to both A and B, or mix payment for services with indemnity benefits. Because many elderly persons do not adequately understand the limitations of Medicare, they are even more confused by the wide assortment of policies designed to supplement Medicare's gaps. It is also difficult to compare the benefits and price of one policy against those offered by other policies.

Many factors, including the size of commissions paid to agents, influence the cost of a policy to a significant degree. Thus, there can be wide variations in the costs of relatively similar policies. Confused shoppers, however, often cannot sift through the bewildering array of policies and benefits to note an inordinate price differential or, more basically, to determine if they are getting the most insurance for their money. Unless policies are standardized, at least to some degree, there is a reduced incentive for insurance companies to truly compete in the open marketplace.

2. *Duplicate/Excessive Coverage*—Because of the complexity of Medicare and private health insurance, many senior citizens fail to understand their insurance needs or the benefits provided by the policies they purchase. For example, few senior citizens realize that no Medicare supplement policy covers physician's charges above the "reasonable" rate approved by Medicare. Most of the aged are unaware that their policies do not pay for services such as physical examinations, custodial care and out-of-hospital drugs.

In an effort to obtain "complete coverage," senior citizens have purchased one, two, or multiple health insurance policies. An all too frequent combination of fear, confusion and ignorance has led them to buy too much insurance when one good Medicare supplement is usually all they need. Moreover, because most Medigap policies include a coordination of benefits clause (i.e., only one policy pays when multiple policies offer the same coverage), duplicate insurance is usually worthless.

3. *Policy Clarity*—Most people, young and old, have difficulty deciphering the complex provisions of an insurance policy. Small print, numerous exclusions, policy riders, and a plethora of medical and legal terminology are but a few of the barriers confronting anyone attempting to evaluate a policy. Often, these problems are exacerbated by failing memories, poor eyesight or other infirmities. Many senior citizens either cannot or do not read their policies carefully and many have difficulty understanding and remembering specific provisions. As a result, many people over 65 rely heavily, sometimes exclusively, on what they are told by insurance agents.

4. *Low Loss Ratios*—One measure of the relative value of an insurance policy to the policyholder is the loss ratio (i.e., the percentage of premiums returned to the policyholder in the form of benefits). Although a policy or group of policies should not be judged solely by loss ratios, Medicare supplements are often criticized for not offering a good return on the premium dollar.

Loss ratios of policies vary considerably for group and individual insurance policies. Blue Cross and commercial insurance companies, which sell *only group* Medigap policies, account for about 60 percent of all such policies.[17] The loss ratios for most group insurance sold by these firms are high, averaging 80 to 90 percent, and offer the best protection for senior citizens.[18] Most group insurance is marketed through an employer, spreading risk more widely and resulting in less direct expense (i.e., overhead and commissions) to the insurance company. The money saved by selling a policy on a group basis is returned to the policyholder in the form of more benefits and lower premiums.

Policies sold on an individual basis by commercial insurance companies usually offer a much lower return to the policyholder. For instance, the average loss ratio of hospital indemnity, nursing home and low value Medicare supplement insurance is about 40 percent.[19] Many Medigap policies, especially the hospital indemnity and dread disease policies, have exceptionally low ratios—some as low as 22 percent.20

The private health insurance industry counters the criticism regarding low loss ratios by arguing that Medicare supplement policies are still fairly new businesses and that loss ratios will increase as more benefits are paid out over time.[21] This argument, however, does not satisfy many critics, who cite the wide range of loss ratio data as evidence that low ratios can be avoided. They also point

to the very high overhead, attributed in part to excessive commissions paid agents for writing new individual policies, experienced by some companies. Companies generally pay commissions ranging from 40 to 75 percent of the premium for the first year for new individual insurance policies. The elderly end up paying for this high commission and get little in return.

5. Clauses for Preexisting Conditions—Many health policies contain a clause which limits or excludes payment for conditions existing at the time of purchase. Most mail-order insurance and insurance purchased on an individual basis use the preexisting, or "pre-x" clause. These Medigap policies usually do not cover any preexisting conditions for six months to a year after the policy is in force.

Because many elderly have long-term illnesses, the pre-x clause can limit, if not void, much of their insurance protection. Also, through policy riders and strict interpretation of the provisions, some companies avoid paying apparently valid claims—even after the waiting period has elapsed. The denial of claims due to pre-x clauses is commonly referred to as "post-claims" underwriting.

One other important problem arises from the application of preexisting clauses. Some elderly patients buy "new" or "improved" policies and discontinue their current coverage, often on an annual or more frequent basis. Commonly referred to as "rolling over" or "twisting," this practice—often done with the knowledge of the agent—leaves many older people completely uninsured because one preexisting clause or the other is always in force. High commissions paid for writing "new" policies are a great incentive for an unscrupulous agent.

6. Claims Handling—A lack of understanding about what a policy covers frequently results in a claims dispute between the insurance company and the policyholder. According to a survey of the 50 states by the House Select Committee on Aging in 1978, the three most prevalent types of complaints filed with state insurance departments are: 1) companies refusing to pay on the grounds of preexisting conditions; 2) companies not paying refunds of the premium; and 3) complaint disputes regarding the amount a company paid on a claim.[22] Complaints to state insurance departments are imprecise but good indicators of a company's marketing practices and how well policyholders understood a policy's benefits package.

Many insurance company and agent abuses go undetected or unprosecuted because many senior citizens do not know that they can file a complaint with the insurance commissioner. Also, older people are reluctant to admit there is a problem or that they have been "taken." Monitoring all of the elderly's complaints, however, including those made directly to the insurance companies, is extremely difficult because many states do not require insurance companies to keep meaningful, comprehensive records of complaints.

7. Mail-Order Insurance—The elderly purchase many Medigap policies through the mail. National senior citizen organizations such as the American Association of Retired Persons (AARP) and an array of large and small insurance companies use the mail to market health insurance. Many Medigap policies sold by mail are not true Medicare supplements; rather, they are limited policies offering indemnity benefits. Companies selling mail-order insurance are often criticized for using deceptive marketing techniques and for playing on the fears of those over 65.

Mail-order insurance poses a difficult problem for those attempting to monitor and regulate the insurance industry. Because of the gaps in regulatory

authority, a mail-order insurance company licensed in one state historically could market its insurance to residents in another state, in some cases effectively circumventing state law. This has been especially true of group insurance policies offered through the mail. The federal government has not assumed responsibility for mail-order abuses because of the limitations imposed by the McCarran-Ferguson Act. State laws are sometimes ineffective for several reasons, one being that they generally do not apply to companies not licensed to do business in that state. Another problem is the nature of group insurance itself. Because group insurance is designed to cover many people in multistate jurisdictions (i.e., a large company with operations in many states), it is virtually impossible to mandate modifications in a group policy that conform to each state's insurance codes.

Probably the most difficult mail-order problem for states, however, is the use of insurance "trusts." Some insurance companies set up trusts in the states where they are licensed for the sole purpose of selling group mail-order insurance in other states. When a policy is purchased, the insurance company files the certificate of insurance with the trust—not in the state where the policyholder resides.

8. Marketing Abuses by Insurance Agents—Congressional investigators, and other officials monitoring the health insurance industry, have found that deception, fraud and high pressure sales techniques are all too common. The following examples of marketing abuses were identified as rather commonplace by the Congressional hearings and by many state health insurance commissioners:

- *Wolf in Sheep's Clothing*—The agent fails on initial contacts with clients to disclose that he represents a for-profit insurance company. He may say he is from Medicare and wants to help seniors with any problems they may have.
- *The Government Look*—Agents and/or companies use advertising materials that tend to associate them with the federal Medicare or Social Security program. Using the above, the agent implies that he is from a government agency without saying so outright.
- *New is Better ("Twisting" or "Existing Policies are Garbage")*—The agent encourages the client to cancel perfectly good policies to sell a new one which results in additional commission fees.
- *Overselling*—The agent sells the client more coverage than he needs or can pay for—also known as "stacking." (If you have two or more policies offering the same benefit, you only get paid once.)
- *Clean Sheeting (or, "Failure to Report Material Conditions")*—The agent fails to report preexisting health conditions of clients to company, ultimately leading to a preexisting condition disqualification of coverage when claims are filed.
- *Forgery*—The agent either signs someone's name to the insurance forms or encourages an elderly client to illegally sign the name of the insured or of a close relative.
- *Scare Tactics*—The agent employs scare language in closing the sale like, "buy now because you may not be able to be insured later."
- *Make the Check Out To Me*—The agent asks that the client make the check out to him. The agent then cashes the check, and does not report the transaction to the insurance company. No policy is issued.

- *The Switch*—The agent sells the client one policy but then switches and provides another for signature at the time of closing.
- *Pie In The Sky (or, "Fine Print")*—The agent misrepresents policy content with words like "no waiting periods," or "this policy will pay for everything."
- *I Work With X*—The licensed salesman allows an unlicensed person to front for him.
- *Group Policy*—The agent represents the policy as a group policy, with the implication that premiums are less, when in fact there is no group and the policy is the same in coverage and premium as an individual policy.
- *The Merry-Go-Round*—An agent who is fired from one company, or leaves voluntarily, visits all the clients to whom he previously sold insurance. He may say something like "my company bought your old company," or "I'm with a better company now" as a pretext to replacing all of company No. 1's policies with those of company No. 2.
- *Teamwork*—Two or three agents visit you. The high-pressure team may ask how much is in your bank account to "help them" determine if you can "afford" the insurance.

The role of insurance companies in promoting or sanctioning deceptive or fraudulent behavior by their agents is difficult to ascertain. Most insurance companies do not condone such practices. It is evident, however, that some companies have instructed their agents in "hard sell" and "pressure" tactics and specifically target sales to exploit the fears and weaknesses of the elderly. In some cases, "training sessions" attended by Congressional investigators entailed little more than learning how to generate leads and get in the door to talk to senior citizens. These investigators found two general characteristics of companies which accounted for the greatest number of marketing abuses: 1) Companies specializing in the sale of individual Medicare supplement health insurance policies; and 2) Companies promoting policies of limited economic value. The larger, more well-known and established companies which sell Medicare supplement policies were the least likely to promote or tolerate marketing abuses by their agents.

Marketing abuses by agents occur for many reasons. Perhaps the most important is the manner in which agents are paid; i.e., on a straight commission basis. Insurance companies often pay the agent 40 to 75 percent of the first year premium for writing new business, but only 5 to 10 percent for renewals. This acts as a tremendous incentive for agents to sell as much new insurance as possible. Some companies also use financial "pressure" to induce their agents to sell more insurance, or to keep them from quitting. For example, Congressional investigators uncovered several instances where the company promoted sales by keeping the agents in debt. This was accomplished by billing the salesmen "enormous sums" for commissions already paid on policies which had been subsequently cancelled. Other reasons insurance companies experience problems with agents include: inadequate screening of agents before they are hired; inadequate internal control mechanisms to monitor policy sales, complaints, and agent practices; and, no on-going method of maintaining direct contact with the policyholders.

MEDICARE—HOSPITAL INSURANCE BENEFITS (PART A)

FOR COVERED SERVICES—EACH BENEFIT PERIOD

SERVICE	BENEFIT	MEDICARE PAYS	YOU PAY**
HOSPITALIZATION... Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic X-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	First 60 days	All but $260	$260
	61st to 90th day	All but $65 a day	$65 a day
	91st to 150th day*	All but$130 a day	$130 a day
	Beyond 150 days	Nothing	All costs
	A Benefit Period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.		
POSTHOSPITAL SKILLED NURSING FACILITY CARE In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge.	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $32.50 a day	$32.50 a day
	Beyond 100 days	Nothing	All costs
	MEDICARE AND PRIVATE INSURANCE WILL NOT PAY FOR MOST NURSING HOME CARE. YOU PAY FOR CUSTODIAL CARE AND MOST CARE IN A NURSING HOME.		
HOME HEALTH CARE	Unlimited visits as medically necessary	Full cost	Nothing
BLOOD	Blood	All but first 3 pints	For first 3 pints

*60 Lifetime Reserve Days may be used only once; days used are not renewable.

**These figures are for 1982 and are subject to change each year.

MEDICARE—HOSPITAL INSURANCE BENEFITS (PART B)

FOR COVERED SERVICES—EACH CALENDAR YEAR

SERVICE	BENEFIT	MEDICARE PAYS	YOU PAY
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital. Some insurance policies pay less (or nothing) for hospital outpatient medical services or services in a doctor's office.	80% of approved amount (after $75 deductible)	$75 deductible* plus 20% of balance of approved amount (plus any charge above approved amount)**
HOME HEALTH CARE	Unlimited visits as medically necessary	Full cost	Nothing
OUTPATIENT HOSPITAL TREATMENT	Unlimited as medically necessary	80%of approved amount (after $75 deductible)	*Subject to deductible plus 20% of balance of approved amount
BLOOD	Blood	80% of approved amount (after first 3 pints)	For first 3 pints plus 20% of balance of approved amount

*Once you have had $75 of expense for covered services in a calendar year, the Part B deductible does not apply to any further covered services you receive in that year.

**YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.

Source: *Guide to Health Insurance for People With Medicare*, developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

CHAPTER II

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[15] *Ibid.*, p. 212.

[16] *Ibid.*, p. 218.

[17] *Abuses in the Sale of Health Insurance to the Elderly: A National Scandal*, p. 119.

[18] *Ibid.*, p. 119.

[19] *Medi-Gap: Private Health Insurance Supplements to Medicare,* p. 23.

[20] *Abuses in the Sale of Health Insurance to the Elderly: A National Scandal*, p. 3.

[21] *Ibid.*, Appendix 1, pp. 151-80.

[22] *Ibid.*, p. 102.

CHAPTER III

Current Issues in the Implementation of the Federal Voluntary Certification Program

THE DEPARTMENT'S VIEW
As Represented by the Health Care Financing Administration Department of Health and Human Services

On June 9, 1980, PL 96-265, the Social Security Disability Amendments of 1980, was signed into law. Prior to the President's signing the bill, the Health Care Financing Administration, DHHS, had begun implementing sec. 507 of this legislation, commonly referred to as the "Medigap Program." By mid-May, HCFA's Deputy Administrator had created a work group to coordinate all aspects of the legislation and had assigned responsibility to HCFA components for its various aspects.

The law requires HCFA to: set up procedures to establish the federal Voluntary Certification Program; provide technical and administrative support to the Supplemental Health Insurance Panel (SHIP); study the effectiveness of state regulatory approaches to Medicare supplements; issue regulations to implement the Medigap program; provide information to Medicare beneficiaries concerning the purchase of private health insurance; and implement the penalty provisions. All of these are new responsibilities for HCFA except the information campaign.

Beneficiary Information Efforts

Even before the genesis of sec. 507, HCFA's Office of Beneficiary Services had embarked on a national information effort to educate Medicare beneficiaries about the purchase of private health insurance and to make them aware of the possibility of the misrepresentation and abusive sales practices which exist and to which they might be subjected.

In conjunction with the National Association of Insurance Commissioners (NAIC), HCFA developed an information pamphlet, "Guide to Health Insurance for People with Medicare," which is available at Social Security offices in both English and Spanish. In addition, through its regional offices and with state insurance departments, HCFA conducts a nationwide training program for volunteers to assist Medicare beneficiaries wishing help in considering the purchase of private health insurance to supplement their Medicare coverage.

As of October 1, 1981, HCFA had conducted over 275 Medigap training sessions, for over 13,000 individuals in every state. HCFA's Office of Public Affairs is also preparing a public service campaign to acquaint Medicare beneficiaries and other affected individuals of the Medigap law and state regulatory programs concerning Medicare supplements. This campaign will be nationwide in scope and provide all entitled beneficiaries with information to help them with their decision to purchase private health insurance to supplement Medicare.

Medigap Operations Staff Established

In order to establish the procedures for a VCP , provide support to the SHIP, and begin implementing the penalty provisions, HCFA created a Medigap Operations Staff (MOS) in its Bureau of Program Operations. The MOS initiated a series of contacts with the NAIC, Health Insurance Association of America, Blue

Cross Association, American Academy of Actuaries, state insurance departments, and various consumer groups. The intent of these contacts has been to keep all interested parties involved and informed about the progress of HCFA's implementation. All of these groups have been extremely interested and active in contributing ideas about the implementation of the Medigap law.

The MOS, with the DHHS Office of the Inspector General (OIG), has developed procedures for handling complaints of possible violations of the penalty provisions. The MOS and the OIG are also working with the Department of Justice, which has the ultimate responsibility for prosecuting companies or agents who are accused of transgressing the law. Allegations received to date chiefly concern the provisions relating to misrepresentation as a government agent and knowingly selling duplicative coverage.

It is HCFA's intent that the federal complaint process not interfere with current state enforcement activities. Rather, federal investigatory and prosecutorial activities are designed to complement the state process by making federal help available where a state's resources or sanctions are limited. Realizing that successful prosecution of these cases, whether at the state or federal level, will have a significant deterrent effect, HCFA and the OIG are anxious to provide states with any assistance they can which will serve to inhibit abuses and fraudulent practices in the sale of these health insurance policies.

Issuance of Medigap Regulations

The Bureau of Program Policy (BPP) in HCFA was assigned the responsibility of writing regulations to implement the Medigap program. A Notice of Proposed Rulemaking (NPRM) was published in the *Federal Register* January 21, 1981. This contained the definitions, standards and specifications to be used by HCFA for its review of policies submitted under the Voluntary Certification Program. During the 60-day comment period, 25 insurance industry, trade associations and consumer groups gave their views on the NPRM. These views were carefully considered in developing the final regulation.

Study of State Approaches

In addition, the law requires that the Department undertake a comprehensive study of the comparative effectiveness of state approaches to the regulation of Medicare supplement policies. At the same time, the study must address the need for standards for, or certification of, health insurance policies other than Medicare supplement health insurance policies sold to Medicare beneficiaries. The Office of Research and Demonstrations (ORD) in HCFA is responsible for conducting this study. To address the issues listed in the law, ORD has begun to survey Medicare beneficiaries through an independent contractor.

This survey of Medicare beneficiaries is being conducted through personal interviews designed to obtain information on consumers' purchasing behavior, the policies they hold, and the circumstances of the insurance sales transactions.

To analyze the issues raised by Congress, ORD will also be obtaining information on insurance companies' policy loss ratios and market shares of Medicare supplement policies and other health insurance sold to Medicare beneficiaries. These data will be obtained from published sources where possible, and will be supplemented by a brief industry survey.

The ORD has developed a typology used to classify states according to the nature and extent of their insurance regulation. Six states which are representative of the regulatory spectrum have been selected to serve as the survey sites. These states are Florida, New Jersey, Wisconsin, California, Washington, and Mississippi.

The results of this study will be needed by the Department in order to fulfill the request by the Congress concerning such issues as whether a mandatory federal regulatory program is needed to assure marketing of appropriate types of Medicare supplement policies, whether there are ways in which state regulations can be enhanced and whether there is a need for standards for other types of policies sold to Medicare eligibles.

Supplemental Health Insurance Panel

On November 6, 1980, four state commissioners of insurance were appointed by the President to serve on the Supplemental Health Insurance Panel (SHIP). The SHIP is composed of the Secretary of DHHS or a designee and the four state insurance commissioners. The Presidential appointees are: Susan M. Mitchell of Wisconsin, William H. L. Woodyard, III, of Arkansas, Roger C. Day of Utah, and Joseph C. Mike of Connecticut. The Director of the Bureau of Program Operations, HCFA, has been designated chairman. The SHIP is charged with determining whether state laws or regulations relative to Medicare supplement health insurance meet the standards and requirements in the federal law.

SHIP is continuing to issue findings concerning state regulatory programs. The Medigap Operations Staff, in its capacity as support staff to SHIP, is providing analysis of the state Medigap programs. The MOS maintains a dialogue with states to provide them with advice on the program and to provide the federal government with insights into the state regulatory process.

As required by law, the Secretary of HHS has transmitted the Panel's report to Congress. This consisted of a list of seven states and three jurisdictions which have not, or are not expected by July 1, 1982, to have regulations in place which are equal to or more stringent than the federal minimum. In the states not meeting the standards by July 1, 1982, the federal VCP will become effective.

THE CONGRESSIONAL VIEW
As Represented by Senator Max Baucus (D-Montana)

The Voluntary Certification Program—An Appropriate Response To The Problems Of The Elderly

The Medicare program imposes limits on the kinds of services covered and sets financial requirements for beneficiaries to meet in return for services. The gaps in coverage have contributed to the growth of a huge market for private supplemental health insurance—the so-called Medigap policy.

To fill the gaps in Medicare, more than 15 million Americans, or about two-thirds of the elderly, have purchased at least one Medigap policy. At a time when Medicare pays for only 44 percent of a senior citizen's health bill, the health insurance protection afforded by supplemental policies is invaluable.

But a decade of investigations reveal a systematic and shocking pattern of abuse in the sale of Medigap policies to the elderly. Since 1971, 19 studies have examined the problems surrounding the sale of private health insurance to Medicare beneficiaries. These studies confirm that Medigap abuse is a national problem demanding national attention.

The House Select Committee on Aging conducted an exhaustive investigation in 1978 documenting the extent of the problem. The Report estimated that the loss to senior citizens in purchasing worthless and duplicative policies amounted to a staggering $1 billion a year.

What else have these investigations and studies disclosed? First, senior citizens receive confusing information about the scope and extent of coverage provided.

Second, unethical sales practices result in tragic situations where older Americans purchase two, three, four and, in one case, as many as 90 duplicative and worthless policies to supplement Medicare.

Third, complex policy language makes it difficult, if not virtually impossible, for Medicare consumers to make informed and intelligent choices about the policies they wish to purchase.

Finally, restrictive benefit clauses often make the policies financially unattractive, when viewed in terms of premium cost to actual amount of coverage provided.

Senior citizens, like most Americans, are uninformed about insurance. An insurance policy is a "blind item"—seniors have no way of judging the value of what they are purchasing. They must accept the representation of agents. They fail to understand the effect of small print commonly contained in such policies which provides that where the senior has more than one such policy, only one policy will pay.

Despite the magnitude of the abuses perpetrated on the elderly, the state response has been inadequate and slow. In an earlier study, this publication reported that only 18 states had laws or regulations affecting the sale of policies to the elderly. Only nine states had adopted minimum standards for Medigap policies and, more significant, only seven states had established regulations setting loss ratio requirements.

The federal VCP represents an appropriate and reasonable response to remedy the problems surrounding the sale of health insurance to the elderly. Some might maintain that, indeed, it is the federal government's responsibility to regulate abuses in this area because the federal government created many of the problems through the enactment of Medicare. But the best argument for the VCP is that it represents a mechanism by which to reduce and discourage the abuses in the Medigap area while encouraging states to play a greater role in the regulation of these policies.

Strengths, Weaknesses and Problems of the Voluntary Certification Program

A number of issues are emerging as implementation of the Medigap Act proceeds. One question concerns whether the VCP applies to all beneficiaries entitled to Medicare benefits or to those individuals entitled by reason of age. In my view, the language of the legislation requires that the Medigap program apply to Medicare beneficiaries of all ages.

As it now stands, the Notice of Proposed Rulemaking (NPR) embodies this interpretation of the law. Some dispute this finding; most notably, the state members of the SHIP who recently agreed to approve state regulatory Medigap problems applying only to the 65 and over population.

A resolution of this disagreement will come when the final regulation is published by the Health Care Financing Administration. Nevertheless, I am confident that the Department will agree that the letter and spirit of the Medigap law is unambiguous, that acceptable state programs must apply to all beneficiaries—including the 3 million who are entitled by reason of disability or end stage renal disease.

Another issue emerging relates to the authority of the Supplemental Health Insurance Panel. The Medigap law provides that the SHIP has sole responsibility for determining whether a state regulatory program meets or exceeds the standard minimum requirement of the VCP. The Panel's authority, however, is limited to one of the evaluation, not interpretation, of the standards and the law.

In my view, the Department of Health and Human Services has the authority to issue regulations which are binding on the Supplemental Health Insurance Panel. The Panel and the Department should meet to develop a workable system to mediate this and similar disputes.

One of the key standards of the VCP is the loss ratio requirement. Under the program, policies must be expected to return to policyholders, in the form of aggregate benefits, at least 75 percent of the amount of premiums collected in the case of group policies, and at least 60 percent in the case of individual policies.

Congressional intent in requiring the loss ratio standard is to ensure that policyholders receive reasonable financial return for their health insurance premium dollars. The loss ratio is an appropriate way to measure policy worth. It is, in fact, the fundamental gauge of economic value in health insurance.

Data on health insurance as a whole show that Blue Cross and Blue Shield plans typically return 90¢ of every premium dollar as benefits. All health insurers return an average 80¢ on the dollar. In view of these statistics, the Medigap loss ratio requirement of 60 percent for individual policies and 75 percent for group policies is a liberal standard. It is simply unconscionable and irresponsible to sanction policies which return only 20 or 30¢ on the premium dollar.

Probable Impact And Utility Of The Voluntary Certification Program On Medicare Beneficiaries

The best possible effect of the Medigap VCP would be a much better informed Medicare consumer, better informed about Medicare and better informed about options for supplemental insurance. Congress expects that certification will make it easier for buyers to identify good insurance policies and make better comparisons before buying.

The worst possible effect of a VCP would be that the certification "seal of approval" would serve as a substitute for consumer comparison shopping. I do not believe this will happen, however, because of the disclosure and readability standards required for certification.

The uniform use of a widely-recognized certification should say to all Medicare beneficiaries contemplating buying a Medigap insurance policy in effect:

> "This insurance policy has been judged to be a good purchase value if you are looking for a policy which will make basic payments in supplementation of your Medicare coverage. The policy will pay, at a minimum, a substantial part of Medicare's coinsurance and deductible charges, and the company selling the policy has a good track record of making payments. You are encouraged, however, to acquaint yourself thoroughly with the contents of this policy, and to shop around for the insurance which best meets your own needs."

This is the basic message that Congress intends to convey to Medicare beneficiaries through a properly implemented certification program.

The history of Medigap abuses which was reviewed by Congress before adopting this legislation showed us three things: 1) an almost universal fear of the rising costs of health care on the part of Medicare beneficiaries, meaning a larger and larger market for supplemental insurance; 2) widespread confusion about available supplemental health insurance options; and 3) case after case of Medicare consumers being taken advantage of through high pressure sales tactics and misrepresentations of policy benefits. This record is replete with circumstances which could have been avoided if the basic consumer tool offered through voluntary certification had been available at the time. Many of the insurance policies purchased by fearful Medicare beneficiaries could never receive certification.

Not all Medicare consumers will need to rely on certification to make a good insurance purchase; all should be encouraged to make much more thorough evaluations of their insurance options. We believe that the certification program will make it easier to do this.

What Does Certification Mean?

One, it is a statement that the policy will cover, at a minimum, a major portion of Medicare Part A and Part B coinsurance charges.

Two, it is a statement that the policy being sold has a pay-out experience which compares favorably with insurance industry norms, and that there is a reasonable guarantee that the policy will pay what it says it will pay. This is true because of the minimum loss-ratio requirements, which provide some insight into the size of the premium and its relation to the benefit expenses of the insuring organization and the claims-paying record of the insurance company.

Three, it is a statement that the policy does not contain preexisting condition clauses of more than six months.

Four, it means that the policy comes with a disclosure statement of all coverage, limitations, costs, rights to cancel, and comparison with Medicare benefits, making it easier for the purchaser to fully understand what he or she is buying and facilitating further comparison shopping.

Five, it means that the policy itself is written in easy-to-understand language, a further aid to comparison shopping.

Six, it means that the consumer can review the policy, and return it with full premium refund within 10 days of sale.

The certification program, therefore, addresses many of the biggest problems faced by Medicare consumers when they buy health insurance: difficulties in understanding an insurance policy, lack of information for comparison shopping, time to reconsider a purchase, and great disappointment over misunderstood preexisting condition clauses when they are discovered too late (which also results, incidentally, in bad public relations for the insurance company).

The presence of the certification seal itself should also preclude many people from being duped by some of the very offensive selling tactics which we found were often used to sell worthless policies to Medicare consumers. We all know that if an unscrupulous salesman is out to con someone, a way around the certification can probably be found. But, if a Medicare consumer knows to look for a certification, it will be much more difficult, for instance, to refuse to show a policy in advance of purchase. And, with clear disclosure provisions, it will be more difficult to make exaggerated claims about an insurance policy's provisions. Apart from the VCP, Congress expects that the strong penalties for unethical selling practices now in the law will help remedy this situation.

Future of the Voluntary Certification Program

PL 96-265 provides that the federal Medigap program will be limited to those states not establishing equivalent programs of their own. Even in those states where it applies, companies are not compelled to participate.

The structure of the VCP is designed to encourage each state to work out its own solutions to the Medigap problem. The effective date of the certification procedure was delayed deliberately to permit the states to enact and implement regulatory programs.

The Medigap law, in other words, gives the benefit to the states. It is, therefore, consistent with the spirit of the Reagan Administration antiregulatory and states' rights emphasis.

Hopefully, the VCP will have a short, but effective, future. When all states have complied by enacting equivalent programs, then the federal program no longer will be necessary. The Reagan Administration would be ill-advised to suggest dismantling a program at a time when senior citizens are still confronted with widespread abuses and a confusing array of supplemental policies. Despite the antiregulatory mood of the public, I believe the majority of Americans support intervention on behalf of our elderly citizens.

Historically, states have had responsibility for regulating the insurance industry. The Federal Medigap program threatens to disrupt the status quo. Many states and companies perceive it as a frontal assault on their authority.

It is my hope that the states will continue to regulate these policies. But senior citizens cannot afford to wait. They have waited far too long already. The VCP will be necessary until all the 50 states have in place programs to protect their older citizens.

THE STATE INSURANCE REGULATORS' VIEW
As Represented by the National Association of Insurance Commissioners

The Voluntary Certification Program—An Appropriate Response to the Problems of the Elderly

There is little doubt that a need exists for regulation of health insurance policies sold to elderly Americans. The unequal bargaining power between insurer and insured in this segment of the insurance marketplace offers a convincing rationale for government oversight and regulation "to protect the weaker contracting party."[1] Although almost everyone agrees that a need exists for regulating health insurance policies sold to the elderly, there is an absence of consensus concerning the type of regulation, amount of regulation, and level of government at which regulation should occur. The specific problems which the elderly face in purchasing health insurance products dictate, to a large extent, the type of regulatory response which is most appropriate.

Type of Problems

Recent studies have disclosed a wide range of market problems and abuses involving the sale of health insurance products to the elderly.[2] These problems and abuses can be grouped into three major categories: marketing abuses, problems involving the value of the insurance product, and problems relating to insurance policy comprehension. Marketing abuses which have been uncovered involve the "stacking" of multiple policies by unscrupulous agents, the "roll-over" or "twisting" of existing policies to policies paying higher agent commissions, and the false representation of certain agents indicating they are associated with the federal Medicare program. In addition to marketing abuses, health insurance, products sold to the elderly may not be a good buy. Health insurance products which offer less than comprehensive benefits or return a low percentage of premiums to policyholders in the form of benefits pose problems for elderly Americans. Finally, elderly Americans have a particularly difficult time reading and understanding their health insurance policies. Although insurance policy comprehension is not a problem unique to elderly Americans, the failing memory, poor eyesight and reduced attention span which often accompany advanced age make the problem of understanding health insurance products particularly acute for older Americans.

Even though all three categories of problems must be addressed by industry and government officials, by far the most serious problem is that of marketing abuses. Much of the testimony before congressional committees and a large share of the literature dealing with the health insurance problems of the elderly have focused on marketing abuses. These abuses insult our sense of justice and fair play and evoke a common desire for remedial action. Moreover, while reasonable persons may differ as to the economic value of an insurance policy or the clarity of its phraseology, few persons would dispute the fact that insurance policy stacking and twisting, along with other forms of policy misrepresentations, constitute reprehensible conduct deserving of strong government sanctions.

Appropriate Regulatory Response

The most appropriate regulatory response to each of the three categories of problems discussed above is one which directly attacks the conduct or circumstances giving rise to the problem. Despite the misinformed opinion of many observers in Washington, existing state insurance laws already establish a wide panoply of regulatory requirements for health insurance policies sold to the elderly. The real question which must be addressed today is not what type of federal law is needed to address these problems, but how can existing state laws be bolstered to more effectively redress the health problems of the elderly?

Improve State Enforcement Capabilities

Existing state insurance laws provide the necessary statutory authority to combat the health insurance marketing abuses described above. All 50 states have enacted legislation governing the licensing of insurance agents and prohibiting sales presentations which "misrepresent the benefits, advantages, conditions, or terms of an insurance policy."[3] In addition, 47 states have promulgated rules specifically prohibiting health insurance sales solicitations which have "the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered, or premium payable."[4] Even though state insurance laws prohibit the type of marketing abuses which have been experienced in the sale of health insurance to the elderly, marketing abuses exist primarily because enforcement of the state laws is difficult. Elderly victims of unscrupulous insurance agents often are poor witnesses in administrative and criminal enforcement proceedings. Furthermore, state insurance departments often lack the staff and resources to effectively enforce the state laws governing deceptive sales and advertising practices. The appropriate regulatory response, therefore, to health insurance marketing abuses involving elderly Americans is to improve the capacity of state insurance departments to enforce existing state laws. Raising the priority of health insurance marketing abuses among local law enforcement officials and improving the investigative resources of state insurance departments are two examples of how better enforcement of state laws can be achieved.

Additional State Regulatory Requirements

The health insurance problems of the elderly involving policy value and policy understanding require a different regulatory response than the problems of marketing abuses. Unlike state laws governing agent licensing and sales solicitations, state laws governing policy worth and policy understanding are not as widespread throughout the states. Even though many states have established general statutory guidelines for health insurance premium rates and certain minimum standards for health insurance policy provisions and benefits, these requirements are not specifically directed at the health insurance policies purchased by the elderly to supplement Medicare. The National Association of Insurance Commissioners (NAIC), on the other hand, has adopted model legislation and regulations which specifically establish minimum benefit, loss ratio, and disclosure standards for Medicare supplement policies.[5] Wider state enactment of the NAIC model legislation and regulations would certainly improve the capacity of existing state laws to address the particular problems of policy worth and policy understanding in the Medicare supplement insurance marketplace.

Shortcomings of the Voluntary Certification Program

Unfortunately, the Voluntary Certification Program (VCP) for Medicare supplement health insurance policies established by sec. 507 of PL 96-265 is a poor response to the problems surrounding the sale of health insurance to elderly Americans. One of the major shortcomings of the VCP is that it ignores the underlying causes of the health insurance problems of elderly Americans: "the twin buzz saws of ever escalating health care costs and constantly decreasing Medicare coverage."[6] As recently noted by the FTC in its study entitled "Private Health Insurance to Supplement Medicare,"

> Any remedy applicable only to medicare supplement insurance or even to all health insurance policies sold to the elderly would not address the fundamental problems experienced by the older people in obtaining and paying for health care. Specifically, no such regulation would affect the situation of the near poor and middle income elderly who are ineligible for Medicaid but cannot afford private insurance.[7]

By creating a regulatory scheme for the federal certification of Medicare supplement insurance policies, the VCP merely addresses the symptoms of the health insurance problems of the elderly and not the real disease. Improving Medicare supplement health insurance loss ratios and minimum benefits will not make Medicare supplement policies more affordable for elderly Americans, even assuming the VCP accomplishes these results. In leading elderly Americans to believe their insurance problems were redressed by enactment of sec. 507 of PL 96-265, the VCP may ironically become the ultimate health insurance fraud perpetrated on older Americans.

The VCP also fails as an appropriate response to the health insurance problems of elderly Americans because it does nothing to remedy the marketing abuses described above. Neither the certification of Medicare supplement policies by the federal government nor the printing of a federal emblem on such policies will deter sales tactics such as policy stacking and twisting. In fact, the existence of the federal emblem may encourage Medicare consumers to exchange their current policies for new policies which offer no better protection or value. Furthermore, there is nothing in the VCP which improves the capabilities of either federal or state officials to prosecute insurance agents under existing state laws governing agent licensure, unfair trade practices, and policy solicitations. The difficult problems of prosecuting unscrupulous agents for marketing abuses will remain despite the requirements of the VCP.

Finally, the VCP is a poor response to the above-mentioned problems of policy worth and policy understanding. By establishing minimum loss ratios for Medicare supplement policies and requiring compliance with the Medicare supplement insurance standards in the NAIC Individual Accident and Sickness Minimum Standards Model Regulation, the VCP theoretically encourages insurance companies to improve the quality of their Medicare supplement insurance policies. Because of the voluntary nature of the VCP, however, there is no assurance that insurance companies will seek the federal emblem contemplated by the VCP. Unlike state insurance laws which establish minimum requirements for Medicare supplement insurance policies as a matter of law, the VCP can be effective only if insurance companies believe some advantage can be gained by obtaining a federal emblem. To the extent marketing strategies can be developed which

avoid the use of the federal emblem, the minimum requirements of the VCP can be ignored. Given the ingenuity and resourcefulness of marketing strategists within insurance companies which sell Medicare supplement insurance policies, this result is not as remote as the proponents of the VCP would believe.

Strengths, Weaknesses and Problems of the Voluntary Certification Program

As a general matter, the greatest strength of the VCP is its tendency to encourage the states to enact regulations which comply with sec. 507 of PL 96-265. To the extent that such regulations establish specific benefit requirements, minimum loss ratios, and disclosure guidelines for Medicare supplement insurance policies, they will improve the capacity of the states to address Medicare supplement insurance problems relating to policy worth and policy understanding. On the other hand, the greatest weakness of the VCP is that it does not address the underlying causes of the health insurance problems of elderly Americans. In addition, its provisions offer no assistance in combating Medicare supplement insurance marketing abuses such as stacking and twisting. Beyond the general strengths and weaknesses of the VCP, its provisions create a number of specific problems for health insurance carriers, state insurance regulators, and the Medigap Operations Staff of HCFA. These problems arise primarily because the VCP establishes regulatory requirements for certified policies which fall outside the broader framework of state insurance regulation.

Problems Involving The Use Of Loss Ratios To Measure Policy Worth

It was noted previously that policy worth is one of the problems surrounding the sale of Medicare supplement insurance policies to elderly Americans. The VCP attempts to address this problem by establishing a minimum loss ratio of 75 percent for group Medicare supplement policies and a minimum loss ratio of 60 percent for individual Medicare supplement policies.[8] While a minimum loss ratio requirement is a proper regulatory tool for measuring policy worth, the specific incorporation of minimum loss ratios in the VCP poses several problems. First, rigid adherance to a minimum loss ratio standard may prohibit necessary action to alleviate problems of financial solidity. Since rates charged by health insurers must not only return reasonable benefits to policyholders but also be adequate to meet benefit claims, there is a danger that federal enforcement of the VCP will ignore questions of financial solidity. This danger is particularly acute in light of the fact that state insurance commissioners retain responsibility for the financial condition of health insurers while the VCP does not mention financial solidity as a factor for federal officials to consider in enforcing the minimum loss ratios under that program. Unless minimum loss ratios are enforced in the context of broader insurance regulatory goals, there is a danger that they will be misused to accomplish one set of public policy objectives to the detriment of other legitimate public policy goals.

A related problem to the narrow use of minimum loss ratios in the VCP is the problem of oversimplification. A single number is used in the VCP to establish minimum loss ratios for both groups and individual policies. It is generally agreed, however, that the numerical value of a loss ratio should vary according to three types of factors: "the type of coverage, the nature of the renewal clause, and the expected amount of average annual premiums."[9] Unfortunately, the VCP

is silent as to how these factors should be taken into account in arriving at the single numerical value it establishes for minimum loss ratios. Even assuming there is sufficient authority vested in HCFA to consider these three factors in regulations implementing the VCP, the rigidity with which the Medigap Operations Staff of HCFA has approached other requirements of the VCP casts doubts on a flexible interpretation of the single numerical values.

Application Of The VCP To The Entire Medicare-Eligible Population

One of the most controversial issues surrounding the VCP has been the debate over the scope of the program. Both the HHS General Counsel and the Medigap Operations Staff contend that the VCP applies to persons who are eligible for Medicare for reasons other than age. Basically, these individuals are entitled by reason of disability or end-stage renal disease.[10] On the other hand, a majority of the members of the Supplemental Health Insurance Panel (SHIP) and the NAIC Task Force on Medicare Supplement Insurance strongly argue that the VCP should not apply to health insurance policies sold to persons eligible for Medicare for reasons other than age.

The argument supporting the application of the VCP to the entire Medicare population is purely legalistic. The HHS General Counsel and the Medigap Operations Staff base their interpretations on the fact that the text of sec. 507 of PL 96-265 makes no explicit distinction between persons eligible for Medicare by reason of age and other persons eligible for Medicare. While this interpretation of sec. 507 may or may not be correct,[11] at no time have the problems of the nonaged Medicare population been discussed as problems deserving of either federal or state action. Not only has the elderly Medicare population been the exclusive focus of attention by both federal and state investigators, but the NAIC model law and individual state laws governing Medicare supplement insurance policies are directed only to the problems of elderly Americans. The *Guide to Health Insurance* required by the NAIC model law, for example, is addressed only to prospective insureds who are eligible for Medicare by reason of age. To require health insurance carriers to disseminate this *Guide* to the entire Medicare-eligible population would be a needless and costly bureaucratic requirement. The debate over the application of the VCP to the nonelderly Medicare population epitomizes the lack of understanding of the Medicare supplement insurance marketplace by federal officials.

Use Of The NAIC Minimum Standards

A third problem contained in the VCP is the explicit reference to the June 6, 1979, version of the NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act as applied to Medicare supplement insurance policies. Although the NAIC model regulation contains explicit requirements for Medicare supplement policies, those requirements pertain only to individual policies. Because sec. 507 defines a "Medicare supplemental policy" as both an individual policy and a group certificate,[12] the explicit reference to the NAIC model regulation is both confusing and inappropriate. In particular, the disclosure requirements in the model regulation take on new meaning when applied to group certificates. Furthermore, the explicit reference to the June 6, 1979 version of the NAIC model regulation provides little flexibility to help insurance

carriers or the Medigap Operations Staff of HCFA interpret the requirements of the VCP. By limiting the requirements of the VCP to the standards of the June 6, 1979 version of the NAIC model regulation, sec. 507 also precludes modification of those standards by the NAIC to eliminate technical problems or to further improve existing standards for Medicare supplement insurance policies. Although the reference to the NAIC model regulation was well intentioned, it is yet another example of the lack of understanding of insurance regulatory practices by the architects of the VCP.

Role Of The Supplemental Health Insurance Panel

A final problem to arise in connection with the VCP is the proper role of the Supplemental Health Insurance Panel (SHIP) in determining whether a state regulatory program meets the requirements of sec. 507 of PL 96-265. According to the language of sec. 507, the VCP does not go into effect in any state which establishes by July 1, 1982, standards for Medicare supplement policies equivalent to the standards of the VCP.[13] Recently the HHS General Counsel and the Medigap Operations Staff of HCFA have contended that SHIP is bound by their respective interpretations of the requirements of the VCP when making decisions concerning individual state compliance with sec. 507. These contentions, if accepted, would relegate to SHIP the role of a figurehead which simply approves the substantive decisions of the HHS General Counsel and the Medigap Operations Staff.

Clearly, the role of SHIP is to make independent determinations of individual state compliance with sec. 507. If, in fact, SHIP is bound by the legal opinions of the HHS General Counsel or the interpretive regulations of HCFA, it has no reason to exist. That Congress intended a different role for SHIP is nowhere more apparent than the comments of Representative Jake Pickle (D-Tex.) during the debate on HR 3236, the bill that eventually became PL 96-265:

> Madame Speaker, the Committee has been asked two questions about the national panel. First, we have been asked is it the intent that the panel make independent determinations with respect to whether a state regulatory program includes standards which are equal to or more stringent than the standards contained in the model regulation approved by the National Association of Insurance Commissioners?
>
> The answer is that the national panel would independently make the determinations, using criteria and detailed definitions based upon the language of this act which it, rather than the Department of Health and Human Services, develops.[14]

As demonstrated by Representative Pickle's comments, SHIP was intended to be an independent decision-making body with the sole authority to determine whether states comply with sec. 507 of PL 96-265.

Probable Impact and Utility of the Voluntary Certification Program on Medicare Eligibles, Health Insurers, and Regulators

The impact of the VCP on Medicare consumers, health insurance carriers, and state insurance regulators will be quite different from what the proponents of the program had envisioned. One predictable result of the VCP which affects all

three groups is the added confusion the VCP will cause in the Medicare supplement insurance marketplace. This confusion will have a very negative impact on all three groups.

Medicare Consumers

A very important factor underlying the Medicare supplement insurance problems of the elderly has been the complexity and confusion of the Medicare program itself. As a staff study of the House Select Committee on Aging noted several years ago, "the complexities of Medicare and the confusing way in which the program has been described to the public have helped fuel the present crisis."[15] It is indeed unfortunate that the VCP only adds to this confusion and exacerbates even more the problems of the elderly in purchasing private health insurance.

The specific feature of the VCP which will cause great confusion on the part of Medicare consumers is its "double option" characteristic. The first option arises because of the provision in sec. 507 of PL 96-265 that the VCP will not take effect in any state which establishes prescribed minimum standards for Medicare supplement policies by July 1, 1982.[16] As a result of this provision it is quite likely that the VCP will not take effect in a large number of states. Second, even if the VCP goes into effect in a given state it is possible that the federal emblem contemplated by the VCP will not be widely used. Because health insurance carriers have a second option of not using the federal emblem, some insurers may elect not to certify their policies for approval by the Secretary of HHS.

The result of this "double option" characteristic of the VCP will most certainly be an inconsistent application of the federal emblem on Medicare supplement insurance policies. Given the fact that the very purpose of the emblem is to provide a benchmark for Medicare consumers in making informed decisions about the purchase of Medicare supplement insurance policies, the inconsistent application of the emblem in the Medicare supplement insurance marketplace is likely to defeat its very purpose.

The tremendous confusion that is likely to result from the inconsistent use of the federal emblem can best be illustrated by a hypothetical case. Suppose state A is found to comply with the requirements of sec. 507 of PL 96-265, but state B is found not to comply. Given the provisions of sec. 507, the VCP will take effect in state B after July 1, 1982, but will not be implemented in state A. Suppose Mr. Jones, an elderly American, lives in state A and desires to purchase a Medicare supplement insurance policy offered by insurance company X. Because insurance company X feels its competitive position in the marketplace would be endangered if it does not obtain the VCP emblem, it gains approval from the Secretary of HHS to use the emblem in state B. The result of this action is that insurance company X's Medicare supplement insurance policy contains an emblem when marketed in state B but contains no emblem when marketed in state A. What is Mr. Jones to believe when he talks with friends in state B or otherwise learns that the Medicare supplement insurance policy of Company X in state B contains a federal emblem and has been certified by the federal government as a "good" buy? Is the policy sold to him in state A a "bad" buy because it contains no such emblem? Should he not renew his policy with Company X in state A and purchase the policy with the federal emblem the next time he travels to state B? Can he

believe company X when a representative of the company tells him that the company's policy in state A is identical to the certified policy in state B? If Mr. Jones is able to decipher the answers to these questions he will possess intellectual powers which are certainly greater than those of the architects of the VCP.

Health Insurance Carriers

Although the VCP will likewise generate confusion for health insurance carriers, the confusion of insurers will be different from that of Medicare consumers. Should the VCP take effect in one or more states after July 1, 1982, health insurance carriers and their agents will be faced with a difficult dilemma. On the one hand, health insurance carriers and their agents will be required to publicize the fact that their health insurance product has received the approval of the federal government and contains the VCP emblem. Absent widespread knowledge of the existence and the meaning of the VCP emblem, there is little value to the VCP. On the other hand, both state and federal laws prohibit insurance carriers and their agents from advertisements or solicitations which associate health insurance products with the Medicare program or the federal government. In fact, at least 35 states prohibit health insurance sales solicitations which

> by their content, phraseology...or other characteristics...appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.[17]

In addition, sec. 507 of PL 96-265 establishes federal criminal penalties for any person who

> falsely assumes or pretends to be acting, or misrepresents in any way that he is acting, under the authority of or in association with, the program of health insurance established by this title, or any federal agency, for the purpose of selling or attempting to sell insurance....[18]

The management of health insurance carriers therefore face a difficult problem in conveying to prospective insureds the meaning of the VCP emblem without violating federal and state laws prohibiting sales solicitations which associate health insurance policies with the federal government. Given the fact that an individual health insurance carrier and its agents may undertake hundreds of thousands of sales solicitations each year for Medicare supplement health insurance policies, the opportunities for transgressing the fine line between publicizing the meaning of the VCP emblem and government prohibitions against associating the policy with the federal government are indeed tremendous.

In addition to coping with the confusion surrounding the meaning of the VCP emblem, health insurance carriers face added administrative costs and paperwork as a result of the VCP. Multistate insurance carriers, for example, will be required to develop two sets of marketing strategies and advertising materials: one for use in states which comply with PL 96-265, and another for states in which the VCP goes into effect. Furthermore, under proposed regulations by the Health Care Financing Administration (HCFA) to implement the VCP, health insurance carriers will be required to submit detailed actuarial data annually to HCFA if they desire to continue to use the VCP emblem.[19] From the perspective of health insurance carriers, it is difficult to see how these additional requirements and costs are justified.

State Insurance Regulators

The VCP will produce both positive and negative ramifications for state insurance regulators. On the positive side, the VCP will provide a strong incentive for state legislatures to enact legislation meeting the minimum requirements of sec. 507 of PL 96-265. To the extent that insurance commissioners in states not having existing legislation feel they need additional legislative authority to address problems relating to policy value and policy understanding, the VCP will help regulators obtain additional legislation. In addition, the passage of sec. 507 of PL 96-265 has highlighted the health insurance problems of the elderly. By raising the visibility of these problems at the national level, individual commissioners may be more likely to obtain necessary funding from state legislatures to bolster enforcement efforts against marketing abuses involving Medicare supplement insurance policies.

It is doubtful whether the positive effects of the VCP will outweigh its negative impact on state insurance regulators, however. The confusion generated by the double option feature of VCP for both Medicare consumers and health insurance carriers will increase the workload of state insurance departments. Complaint handling personnel, for example, can anticipate a significant increase in the number of of inquiries and complaints regarding the meaning of the VCP emblem. There will also be additional paperwork required by individual insurance departments in submitting to the SHIP evidence that the laws and regulations of their state meet the minimum requirements of sec. 507 of PL 96-265. Finally, state insurance regulators have already expended a significant amount of time, both individually and collectively, informing the HCFA Medigap Operations Staff about health insurance regulatory practices. Although the Medigap Operations Staff was initially receptive to the suggestions of state insurance regulators on how to implement some of the requirements of the VCP, this receptiveness has diminished in recent months. To the extent differences of opinion arise between the Medigap Operations Staff and state insurance commissioners, additional time and resources will be wasted arguing over interpretations of the VCP.

Future of the Voluntary Certification Program

The future of the VCP is uncertain at this time. The shortcomings of the VCP as a regulatory response to Medicare supplement insurance problems and the confusion certain to result from its implementation are compelling reasons for its repeal. However, the misperceptions which surrounded the original enactment of the VCP by the Congress must be overcome before the Congress can be expected to repeal the program. Although the political mandate of the Reagan Administration to return to the states powers assumed by the federal government in recent years is a positive force in this direction, it is not clear whether this force is sufficient to overcome the misperceptions surrounding the VCP.

There is little doubt on the part of state insurance commissioners that regulatory responsibility for Medicare supplement insurance problems should reside in the states. Putting aside the merits of the VCP as an appropriate regulatory response, it makes little sense to fragment regulatory responsibility for the health insurance problems of elderly Americans between the federal and state governments. Existing state activities involving agent licensing, regulation for financial solidity, consumer complaints and policy approval are ongoing state

functions which provide the necessary regulatory framework to redress the Medicare supplement insurance problems of elderly Americans. The appropriate federal response to Medicare supplement insurance problems is not to bypass this existing state regulatory framework, but to bolster state enforcement capabilities. Complementary federal criminal penalties such as those in sec. 507 of PL 96-265 accomplish this, while the VCP established by that section does not. Although the state insurance regulatory system can be improved to more effectively address the health insurance problems of elderly Americans, the basic structure of the system is sound and offers much more hope for remedial success than any piecemeal federal program like the VCP.

False Premises Underlying the Voluntary Certification Program

A primary impetus for the enactment of the VCP under sec. 507 of PL 96-265 has been the findings and conclusions of the November 28, 1978, staff study of the House Select Committee on Aging entitled *Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal.*[20] The staff study specifically recommended enactment of a voluntary federal certification program "to help ameliorate the problems surrounding the sale of health insurance to the elderly."[21] Even though the staff study provided clear documentation of problems elderly Americans face in purchasing Medicare supplement health insurance policies, it is replete with internal contradictions and exaggerated conclusions. Many of the current misperceptions in Washington about the merits of the VCP as a viable solution to the health insurance problems of elderly Americans can be traced to the deficiencies of the staff study. Because these misperceptions have been instrumental in establishing the premises for the VCP, a brief discussion of the most egregious contradictions and exaggerations in the staff study may help in further understanding the shortcomings of the VCP.

"Widespread Abuses"

One of the premises for enacting sec. 507 of PL 96-265 was that federal legislation was needed to counter "widespread abuses" in the sale of Medicare supplement health insurance policies to elderly Americans. This premise was supported by the conclusion in the staff study that Medicare supplement health insurance abuses "were found to be widespread and of a protracted nature."[22] Although numerous examples of abuses were uncovered in testimony before the House Select Committee on Aging and through investigations by the Committee's staff, there was a distinct lack of evidence on the question of whether abuses of the type identified by the Select committee were "widespread." To the contrary, information uncovered by the committee's staff reveals that the extent of abuses in the sale of Medicare supplement insurance policies to the elderly was less than widespread. If such abuses were not as frequent as the committee's staff alleged, serious doubts can be raised about the need for legislation at the federal level to redress Medicare supplement insurance abuses.

Market Share Information

Information in the staff study indicates that approximately 19 million Medicare supplement health insurance policies were in force in 1978.[23] The study

further indicates that Blue Cross/Blue Shield plans and commercial insurers writing group policies accounted for approximately 60 percent of these policies in 1978.[24] Since the staff study concludes that Blue Cross/Blue Shield policies pose "few problems" and the loss ratio experience of group policies is "acceptable,"[25] the conclusion that Medicare supplement insurance abuses were widespread seems to be exaggerated. The staff study attempts to sidestep this apparent exaggeration by claiming that Medicare supplement insurance policies comprising the remaining 40 percent of the marketplace constitute "a colossal racket."[26] However, the staff study makes an earlier admission that "there are some reputable companies in this group,"[27] leading the reader to question whether a reputable company would participate in a "colossal racket." Even more surprising, the staff study provides the results of a loss ratio survey of companies writing individual Medicare supplement insurance policies which reveals that 13 of 38 companies surveyed, or 34 percent, returned premiums to insureds in the form of claims at rates greater than 60 percent.[28] While this slight discrepancy between the staff study's conclusion and its own factual data may have eluded the Congress when it passed sec. 507 of PL 96-265, it has not escaped the attention of state insurance regulators who are familiar with conditions in the Medicare supplement insurance marketplace.

Consumer Complaint Information

In its survey of state insurance commissioners the staff study found that the average state received 9,641 insurance complaints each year, of which 2,759 related to the sale of health insurance.[29] Projected on a national level, these figures would produce approximately 140,000 health insurance complaints a year. Accepting the staff study's estimate that about 50 percent of all complaints are justified,[30] justified health insurance complaints for 1978 would have totaled approximately 70,000. If it is assumed that every health insurance complaint in 1978 involved a Medicare supplement policy and that for every reported valid complaint there was an additional unreported valid complaint, valid Medicare supplement insurance complaints for the year surveyed by the staff study would have approximated 140,000. If this number of valid Medicare supplement insurance complaints is divided by the total Medicare supplement insurance policies in force as estimated by the staff study—19 million—the staff figures produce one valid Medicare supplement complaint for every 135 Medicare supplement policies in force. Despite this information, the staff study concluded that "abuses were found to be widespread and of a protracted nature."[31] The only observation which can be made about this conclusion is that the authors of the staff study were more concerned about emphasizing their personal opinions than supporting their conclusions with objective data.

"Inadequate State Regulations"

A second important premise underlying the VCP is that state insurance laws do not adequately address the Medicare supplement insurance problems of elderly Americans. It is not surprising that this premise finds support in the conclusion of the staff study that "substantial gaps exist in the area of state regulations."[32] To support this conclusion the staff study found that "only six states have promulgated specific regulations to address abuses in the sale of Medigap

insurance."[33] A closer view of state insurance laws reveals that neither the staff conclusion nor its finding was supported by information available to the staff at the time of its study.

State Statutes

Had the staff of the House Select Committee on Aging decided to consult the insurance codes of the various states at the time of its 1978 study, it would have found that all 50 states had unfair trade practice laws[34] and agent licensing laws[35] which clearly could be used to combat Medicare supplement insurance marketing abuses. The staff would likewise have found that at least 40 states had statutes delegating to the insurance commissioner the authority to disapprove Medicare supplement health insurance rates which did not return to policyholders benefits that were reasonable in relation to the premiums charged.[36] Furthermore, the staff would have found that 47 states had statutes establishing minimum policy provisions and benefit standards for health insurance policies sold in the states, including Medicare supplement health insurance policies.[37] While it is true that these statutes do not specifically mention Medicare supplement insurance policies, they nevertheless provide state insurance commissioners with sufficient authority to take remedial action to correct the type of Medicare supplement insurance problems identified in the staff study. Although the staff study acknowledged the views of state insurance commissioners that they already had in place "sufficient authority and regulations which would allow them to move against abuses" in the Medicare supplement insurance field,[38] the authors of the Staff Study apparently felt that state insurance commissioners did not know how to interpret their own state laws.

Questionnaire Results

Although conclusions about the adequacy of state regulations may have been difficult to obtain by researching the various state insurance codes, the authors of the staff study were clearly negligent in ignoring the results of their own questionnaire survey of state insurance commissioners. For example, despite the staff study conclusion that "not one state responded that it had the authority to regulate health insurance rates,"[39] Table K in the staff study reveals that 40 state insurance commissioners responded affirmatively to the question whether they had the authority to disapprove insurance policies if premiums are deemed excessive, inadequate or unfairly discriminatory.[40] Moreover, while the staff study concluded that only six states had taken action to stem abuses applicable to Medicare supplement insurance policies,[41] responses to the questionnaire survey of state insurance commissioners indicated that 21 states required minimum loss ratios for health insurance policies,[42] 33 states had minimum policy provisions requirements for health insurance policies,[43] including Medicare supplement policies, and 17 states had preexisting condition standards for health insurance policies.[44] Thus, inconsistencies between the staff study's conclusions concerning the adequacy of state regulation and the results of its questionnaire survey of state insurance commissioners leave serious doubts about the ability of the authors of the staff study to assess the adequacy of state insurance laws.

Conclusion

The foregoing examples of the contradictions and exaggerations in the 1978 study of Medicare supplement health insurance abuses by the staff of the House Select Committee on Aging are very relevant to any assessment of the merits of the VCP under sec. 507 of PL 96-265. Questions concerning the extent of Medicare supplement abuses and the adequacy of existing state laws have a direct bearing on whether any form of federal legislation is either appropriate or needed. Furthermore, it is no coincidence that there exists a basic lack of understanding of insurance regulatory practices in both the staff study and the text of sec. 507 of PL 96-265. Hopefully, there is still time to eliminate the adverse consequences of this lack of understanding before the VCP can take effect on July 1, 1982.

[1] Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law,* 45 MINN. L. REV. 471,523 (1961).

[2] *E. g.,* A. DENOVO & G. SHEARER, FTC OFFICE OF POLICY PLANNING, PRIVATE HEALTH INSURANCE TO SUPPLEMENT MEDICARE 15-23 (July 1978) [*hereinafter cited as* FTC STUDY]; T. VAN ELLET, MEDIGAP: STATES RESPONSES TO PROBLEMS WITH HEALTH INSURANCE FOR THE ELDERLY 14-18 (October 30, 1979) [*hereinafter cited as* T. VAN ELLET]; STAFF OF HOUSE SELECT COMM. ON AGING, 95TH CONG., 2D SESS., ABUSES IN THE SALE OF HEALTH INSURANCE TO THE ELDERLY IN SUPPLEMENT OF MEDICARE: A NATIONAL SCANDAL 39 (November 28, 1978) [*hereinafter cited as* HOUSE STAFF STUDY].

[3] *See for example* ALA. CODE §27-12-23.

[4] Only Alaska, Hawaii and Montana do not have specific advertising regulations governing accident and sickness policies.

[5] The NAIC has taken two approaches to guidelines for medicare supplement insurance policies. One approach establishes specific medicare supplement insurance requirements as part of the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act and Regulation. *See* I NAIC PROCEEDINGS 394-96 (1979); II NAIC PROCEEDINGS 339 (1979). A second NAIC approach establishes similar, but not identical, requirements for medicare supplement insurance policies through the "free standing" NAIC Medicare Supplement Insurance Minimum Standards Model Act and Regulation. *See* I NAIC PROCEEDINGS 453-56, 470-81 (1981).

[6] HOUSE STAFF STUDY, *supra* note 2, at 317.

[7] FTC STUDY, *supra* note 2, at 73.

[8] Act of June 9, 1980, Pub. L. No. 96-265, § 1882(c) of § 507, 94 STAT. 477 (*adding* 42 U.S.C. § 1395 ss(c)).

[9] I NAIC PROCEEDINGS 414 (1980). *See also* C. Habeck, *Coping with Minimum Loss Ratio Regulation,* BEST'S REVIEW 19 (May 1978).

[10] According to HCFA, 2.9 million Medicare enrollees of the 27.9 million total Medicare enrollees in 1979 were disabled beneficiaries. Thus, a little more than 10 percent of all Medicare beneficiaries are eligible for Medicare by reason of disability. Generally, this disability must have existed 24 consecutive months prior to eligibility or be the result of end stage renal disease. *See* HCFA OFFICE OF RESEARCH DEMONSTRATIONS & STATISTICS, HEALTH CARE FINANCING NOTES 1 (1979).

[11] The NAIC has pointed out to the HCFA Medigap Operations Staff that the scope of section 507 of Public Law 96-265 is at least open to question. Because subsection 1882(b)(1)(A) of the Social Security Act specifically references the NAIC Model Regulation to Implement the Individual Accident and Sickness Minimum Standards Act and because the scope of the NAIC Model Regulation is limited to health insurance policies sold to persons eligible for Medicare by reason of age, there is a contradiction between subsection 1882(b)(1)(A) and other language of section 507 applying that section to all persons eligible for Medicare. This contradiction is certainly legal grounds for interpreting the scope of section 507 to be limited to persons eligible for Medicare by reason of age.

[12] Pub. L. No. 96-265, § 1882(g)(1) of § 507, *supra* note 1, *adding* 42 U.S.C. § 1395 ss(g)(1)).

[13] *Id.* § 1882(i)(1) of § 507, *adding* 42 U.S.C. § 1395 ss(i)(1)).

[14] 126 CONG. REC. 3970 (May 22, 1980).

[15] STAFF OF HOUSE SELECT COMM. ON AGING, 95TH CONG., 2D SESS., ABUSES IN THE SALE OF HEALTH INSURANCE TO THE ELDERLY IN SUPPLEMENT OF MEDICARE: A NATIONAL SCANDAL 319 (November 28, 1978).

[16] Act of June 9, 1980, Pub. L. No. 96-265, § 1882(i) of § 507,94 STAT. 477 (*adding* 42 U.S.C. § 1395ss(i)).

[17] *See for example* Michigan Insurance Rules § 500.664 (2) (August 21, 1975).

[18] Pub. L. No. 96-265, § 1882(d)(2) of § 507, *supra* note 2, (*adding* 42 U.S.C. § 1395ss(d)(2)).

[19] 46 Federal Register 6307 (January 21, 1981)(*adding* 42 C.F.R. § 403.251).

[20] *See generally* HOUSE STAFF STUDY, *supra* note 2.

[21] *Id.* at 320.

[22] *Id.* at 319.

[23] *Id.* at 309.

[24] *Id.* at 310.

[25] *Id.* at 309-10.

[26] *Id.* at 317.

[27] *Id.* at 119.

[28] *Id.* at 120.

[29] *Id.* at 288 (Table K).

[30] *See id.* at 253.

[31] *Id.* at 319.

[32] *Id.* at 323.

[33] *Id.* at 316.

[34] *See for example* CAL. INS. CODE § 790.03 (West).

[35] *See for example* OHIO REV. CODE ANN. § 3905.01 (Page).

[36] *See for example* MASS. GEN. LAWS ANN. ch. 175, § 108.

[37] *See for example* N. Y. INS. LAW § 141-a (McKinney).

[38] HOUSE STAFF STUDY, *supra* note 2, at 327.

[39] *Id.* at 316.

[40] *Id.* at 291 (Table K).

[41] *Id.* at 319.

[42] *Id.* at 300 (Table T).

[43] *Id.* at 298 (Table R).

[44] *Id.* at 299 (Table S).

THE CONSUMERS' VIEW

As Represented by the National Retired Teachers Association and American Association of Retired Persons

The Need For Regulation In The Medigap Marketplace

The elderly are today living with the consequences of limited information or misinformation about so-called Medigap insurance policies. The lack of standardization and the complexity of available coverages make comparison shopping and price competition nearly impossible; duplicate coverage is the rule and not the exception; few older Americans' coverage ever meets their expectations; and most Medigap policyholders are reluctant to challenge high rates of claim denial for fear of not being able to obtain health insurance protection due to their advanced age and/or existing health problems.

Thorough investigations made by the Federal Trade Commission and the House and Senate Committees on Aging have firmly documented widespread abuse and unscrupulous practices in the sale of "Medigap" policies to elderly persons. The record is clear and the problem is obvious. Every year thousands of elderly persons, fearing that even a minor illness could financially devastate them, purchase private health insurance which proves to be duplicative or of questionable value in meeting their true health care needs.[1] Too often, they make these purchases in an information vacuum, with little or no information other than that provided by an insurance salesman or advertising received through the mail to aid them in making a rational purchase decision. Without the protection of government regulation to ensure at least a fully reliable and accurate presentation of the terms and conditions of the Medigap policy they purchase, it is almost impossible for the elderly to make a rational and appropriate purchase in this marketplace.[2]

With little policy standardization, potential buyers seldom are able to comparison-shop. Therefore, Medigap policies usually do not compete on the basis of price and generally offer significantly lower rates of return in benefits paid to purchasers. This situation is initially caused by a multitude of factors, not the least of which is the complexity of Medicare's benefit structure combined with the physical limitations which often impair the ability—particularly of the frail elderly—to examine in detail the terms of a supplemental policy and to decide whether it truly meets their needs.

The McCarran-Ferguson Act (15 U.S.C. 1011 et seq.) has provided the states the right and responsibility to regulate the business of insurance. Therefore, states have traditionally been responsible for regulating the sale of Medigap or Medicare supplemental health insurance policies—though until the recent passage of federal legislation (P.L. 96-265, the "Baucus Amendment"), only a limited number of states have adopted laws and regulations specific to Medigap insurance. And yet despite the current hyperactivity in this area, the nature and scope of regulation varies greatly from state to state (causing problems for the elderly as potential policy purchasers) and enforcement of existing regulations is uneven at best.

Therefore, our Associations have a number of concerns relating to the need for an effective regulatory program. First, our Associations contend that the regulations implementing the federal Voluntary Certification Program (VCP)

must fully recognize that this program is meant to establish *minimum* standards (P.L. 96-265), or threshold levels upon which states will build their own minimum requirements. As such, it should also be clear that serious problems in the advertising and sale of indemnity and dread disease policies are not even being addressed within the context of this regulatory or standards-setting effort. Also, there is widespread misunderstanding (and misinformation) as to the items and services that typically are *not* covered under so-called Medigap policies, including: custodial nursing and home care; prescription drugs; eyeglasses and examinations; and dental care.

The rapid rise in health care costs experienced over the past decade and the numerous benefit gaps existing in the Medicare program have undoubtedly exacerbated difficulties older Americans face in purchasing supplemental policies. The federal government, having created substantial gaps in the Medicare program, has a responsibility in the absence of effective state action to protect elderly Medicare beneficiaries against fraud, abuse and misrepresentation in the sale of Medigap policies. Undoubtedly, every time the Medicare program is altered beneficiaries find it even more difficult to comprehend the nature and extent of Medicare coverage, and also the gaps they may want to try to fill with private supplemental insurance policies. Substantial increases in cost sharing liability currently being legislated by the Congress are but the most recent examples of precipitous benefit cuts and program changes which serve to further complicate an already complicated situation.

In 1967, Medicare's first full year of operation, the average health bill for an aged person was $532, of which Medicare paid 41 percent. By 1980, the average bill had increased to approximately $2,500, with Medicare picking up only 38 percent. While the average health bill for the elderly over this period increased more than fourfold, their average out-of-pocket expense for health care in 1980 was $963, or a full 220 percent higher than in 1967. Private health insurance played a very small role, covering only 5 percent of the elderly's health care bill during this period.[3] This increasing out-of-pocket liability of the older consumer of health services demonstrates just how vulnerable the aged are to the present inadequacies of public-private health care programs and the absolute necessity of public and private agencies joining together to improve this situation by fashioning a truly protective regulatory framework governing the sale of Medigap insurance.

This growing, direct out-of-pocket responsibility the elderly are incurring for their health care is steadily increasing the opportunities for deceptive practices in the sale of Medigap policies. It is clear from our Associations' surveys and work with our members that very few beneficiaries understand the complexities of Medicare and its gaps. Lacking information, many older Americans do not realize that insurance sold with a claim to cover all of Medicare's gaps rarely include the largest gaps—those medical services for which Medicare pays nothing (e.g., custodial nursing home care, out-of-hospital prescription drugs). For the most part, insurers offer benefits for services *not* covered by Medicare far less frequently than benefits for the noncovered costs of covered services; that is, Medicare's deductibles and coinsurance charges for hospital and physician services. Where private coverage is available for essential services not included under Medicare, such "major medical" protection has relatively low ceilings on benefits, which limits the protection such policies afford the beneficiary against catastrophic health expenses. In this regard, providing protection via Medigap policies for up

to 365 days of in-hospital care is of very little benefit to the vast majority of elderly Medicare beneficiaries, when at the same time these policies are largely ineffective in dealing with the major source of catastrophic health expenses for the elderly—long-term (nursing home) care.

Clearly, the complexities of Medicare and the confusing manner in which the program has been described to beneficiaries and to potential purchasers of Medigap policies have fueled the present crisis. Since reform regulations adopted by 50 states relating to the federal Medicare program cannot help but be confusing, the VCP (with minimum federal standards) adopted by the Congress must be supported. Such intervention in the marketplace is necessary in order to assure a certain uniformity in regulations applicable to the sale of Medigap policies in every state across the country. Our Associations believe that the goals or standards by which the VCP should be judged revolve around the program's ability to protect the elderly consumer by providing adequate information, requiring sufficient standardization to promote cost comparisons and, ultimately, by regulating the quality of the product sold by requiring that Medigap policies meet certain minimum standards and seeing to it that these standards are enforced. Quite obviously, enforcement of the law along with swiftly administered criminal penalties for felonious activities is central to the overall efficacy of this approach to solving the Medigap problem.

Our Associations believe that, in light of the magnitude and persistence of the problem at hand, a program of mandatory certification is justified. However, realistically, since the states are in the best position to monitor and enforce compliance with a series of consensus standards, it seems advisable to give them one more opportunity to move "voluntarily" against continued fraud and abuse in the advertising and sale of Medigap policies. We do not make the recommendation for a more aggressive regulatory approach lightly. The Congress has been discussing the need for a model law covering mail-order (or direct response) solicitations for over a decade with no results until passage of P.L. 96-265.[4] We fully realize the impact on consumers that a mandatory program could have in terms of possible increased premium costs or lack of flexibility in consumer choice. However, such potential negative effects must be weighed against the improved benefit coverage and consumer protection that would likely occur. Tradeoffs such as this must be evaluated so that any mandatory certification program can strike an appropriate balance between negative and positive effects.

A number of caveats seem in order to our aforementioned statements of support for PL 96-265, the Baucus Amendment. Specifically, the proposed regulations implementing the VCP[5] place an inordinate emphasis on consumer education as a force in improving the general quality of Medigap policy offerings. It is clear from our Associations' work that purchasers and potential purchasers of Medigap policies are not fully cognizant of what the term "Medigap" actually implies, much less aware of the technical issues involved (e.g., loss ratios). According to recent nationwide surveys we have conducted of Medicare beneficiaries, nearly half are less than fully aware of their Medicare benefits and rights, not to mention what is required to supplement these benefits. Regulations implementing PL 96-265 should more fully spell out the activities that are to be undertaken in terms of consumer (beneficiary) awareness if the objectives of this legislation are to be achieved. This commitment to an informed consumer is essential to the success of this program.

A central element to maintaining the integrity of this regulatory effort involves the intent of the Congress. Insurance companies marketing Medigap policies supposedly will not have to submit any more information than they previously have had to submit to the states for policy approval. This assumption only highlights the need for increased attention on enforcement efforts and a particular focus on criminal violations of this statute. State insurance commissioners and state and local prosecuters have had a most difficult time in monitoring the actions of companies and agents engaged in the sale of Medigap policies. While many older Americans are simply not aware of the fact that they are being victimized by unscrupulous agents, others are often too embarrassed to admit that they have been victimized or to participate in court proceedings against agents. Because few states have comprehensive regulations or legislation governing the advertising and sale of Medigap policies, the quality of the enforcement effort is of great importance. Unfortunately, the level of success experienced by the states in this regard leaves a great deal to be desired. Of equal concern must be the "defunding" of many state insurance offices charged with these enforcement mandates. In light of the difficulty in proving criminal behavior, it is particularly important that regional inspectors general and U.S. attorneys fully realize the significance of this legislation and aggressively prosecute where the evidence justifies. It is the Department's responsibility to act as an advocate of the elderly in this regard, and this should be reflected in the final program regulations and oversight activities of the Congress and the Health Care Financing Administration (HCFA).

Strengths, Weaknesses and Problems of the Voluntary Certification Program

Focusing first on some of the strengths of the VCP, we note that, unlike the National Association of Insurance Commissioners (NAIC) Model Standards, the proposed regulations implementing P.L. 96-265 do address the need for effective regulation of the sale of group and mail-order (direct response solicitations), as well as individual Medigap policies—best exemplified by the establishment of mandatory, not optional, loss ratios for all of these policies. Still, our Associations believe that equity demands the incorporation of all Medicare beneficiaries in the VCP. Contrary to the opinion of the NAIC Task Force on Medicare Supplemental Insurance,[6] we believe that the disabled and those with end-stage renal disease encounter problems similar to those the elderly encounter in purchasing Medigap policies. While the focus of the NAIC Model Standards, as well as federal law, has been the health insurance problems of the elderly, numerous problems extend across all classes of Medicare beneficiaries including: abusive sales practices; deceptive advertising; and inadequate (or even deceptive) disclosure of key information on benefits, exclusions, limitations, loss ratios and renewability. Inclusion of the nonelderly within the VCP is particularly advisable at a time when the Congress and the present Administration are looking with great favor upon a voucher, pro-competition approach to financing and delivering health care services which is based largely upon informed consumers (aged and nonaged) making calculated choices among a variety of health plans. Assuming that the disabled are able to obtain supplemental health insurance, then HCFA has an equal responsibility to provide them with information. The NAIC does not seem to have recognized this need, though the regulations for the VCP do.

We also believe, however, that the VCP is deficient regarding mental health services. In not addressing the substantial gaps in Medicare's mental health benefits, the VCP is perpetuating the discriminatory treatment of the mental health needs of the elderly. As such, we would recommend that HCFA include specific guidelines for mental health services under supplemental policies.

Mandating compliance with certain benchmark loss ratios is clearly a positive aspect of the VCP. Our Associations have seen this most recently in the competitive bidding among a number of insurance carriers for our organizations' supplemental insurance business. In response to requiring a 75 percent loss ratio, we have seen those companies who were unsuccessful in winning our health insurance contract respond competitively with assurances of similar high pay-outs or return on premium dollars. Still, we have some concerns about the manner in which the VCP will use loss ratios to measure policy worth. In particular, we agree with the NAIC recommendation that any loss ratio calculation period must be consistent for all insurers—to facilitate comparability. Yet, achieving such comparability is likely to be most elusive. To abide by Sec. 1822(e) of the Social Security Act and furnish all Medicare beneficiaries with information that will enable them to make informed choices among Medigap policies is a herculean task for the Secretary. Massive problems are involved in even defining for the beneficiary what a loss ratio is, much less how to use it to measure and compare policy worth. To even start to communicate this understanding to beneficiaries requires a substantial commitment on the part of this Administration and the federal government to consumer education—a commitment that has not existed in previous administrations concerning even the Medicare program in general.

One additional point that is not clear from the proposed regulations or from the legislative history is the rationale for applying a much lower loss ratio to mail-order or direct response policies. This should be a primary focus of the HCFA studies and evaluations. We also believe that additional data beyond that which HCFA has asked for should be required as part of the process of developing and reviewing loss ratios. Included should be some order of magnitude of: 1) administrative costs as a percentage of benefits paid (and premium income); 2) sales commissions paid over the calculated period (as a percentage of total premium dollars received); and 3) the portion of policies converted (or "rolled over") during this same period.

Furthermore, HCFA and the Supplemental Health Insurance Panel (SHIP) need to receive for purposes of policy review information on any state enforcement action (including those pending) and any restrictions on the marketing of a given policy in any state.

To further clarify alternative policy coverage and comparability we strongly believe that any [voluntary] standards need to require the specific statement on each supplemental policy sold to the effect that coverage and thus benefits will (or will not) automatically be changed to coincide with any changes, statutory or otherwise, in Medicare deductibles and coinsurance liability. This would also facilitate providing the policyholder ample notice of any corresponding premium increases.

Our Associations have some concern with the scope of the characterization of policies as "being offered [for sale] by a private entity" (sec. 403-212). Whereas subsection C of the regulations does exempt most of these "private entities," i.e., Taft-Hartley Trusts, other plans can still be offered by noninsurance companies

and as such escape for the most part being regulated as insurance companies by the states.

Our Associations are also strongly supportive of the protection accorded beneficiaries in those instances when a previously certified policy is decertified. It is extremely important that policyholders immediately be appraised of such a status change and that such information be conveyed in an objective, simple, and straightforward fashion. We feel that such disclosure by the company underwriting the policy, with the notice being subject to preclearance by the state insurance department and/or HCFA (if federally certified), is important if a better informed and educated consuming public is to act as a meaningful force in improving the general quality of Medigap policy offerings.

At issue is also the role of the federal government's emblem. The use of any emblem to be included on policies sold is presently prohibited in a number of states. Quite apart from this concern, however, is the idea that a state with more rigorous, higher standards for Medigap policies sold within its boundaries may desire to use a separate emblem to signify its more demanding standards and oversight. This is well within the spirit of P.L. 96-265 and should be encouraged.

It is clear to us that SHIP and HCFA *must* maintain oversight to assure policyholders that the states have effectively implemented their approved regulatory programs. Right now there does not seem to be an appropriate mechanism in place for the continuous review of state programs to assure satisfactory implementation of those that have received deemed certification status. We would add that any review criteria developed should include: the level of complaint activity; documented enforcement problems; and business volume.

SHIP and HCFA should establish specific procedures for reviewing SHIP's determinations before they become effective, particularly in the six months prior to the effective date of the VCP (July 1, 1982). Since the intent of the Baucus Amendment is to provide the states and private insurance companies an incentive to act in a conforming manner, all plans should be provided the fullest possible opportunity for policy review and adjustment.

Probable Impact and Utility of the Voluntary Certification Program from the Consumer Perspective

As noted earlier, the National Retired Teachers Association/American Association of Retired Persons believes that the goals and standards by which the VCP should be judged revolve around its ability to protect the elderly consumer by providing adequate information for informed choices. This then mandates that policies meet sufficient standardization requirements so as to improve cost comparison and, ultimately, regulate the quality of the products sold by requiring that Medigap policies meet certain minimum standards. If this is to be accomplished, the standards must be enforced. While the new law sets criminal penalties for noncompliance, the key to the new certification program's success is in the utility of the information that is provided, and the awareness of the consumer in putting this information to work.

Under the proposed regulations there is little mention of consumer awareness and information. Older adult organizations such as NRTA/AARP, in representing their constituency, must promote this certification process and provide clear

information for Medicare beneficiaries in order for them to be effective consumers. While insurers and government agencies can provide this type of information, there are problems that would limit their impact. The first is the limitation imposed on government agencies as to what can or cannot be stated about particular types of policies. This limits the scope of such government publications and, while the information contained is factual, it does not necessarily represent the pros and cons of particular policy options. Nor would these publications deal with the types of Medigap insurance that are outside the purview of PL 96-265, or their pros and cons.

The impact of materials provided by insurers or their representative associations has limited impact because of the perception, on the part of the beneficiary, of the implied corporate interest in developing such a guide. Regardless of the accuracy or extent of the materials, beneficiaries may sense that they are not receiving a full presentation of the facts, if the material is prepared by a particular insurance company or association of companies.

Given these circumstances, it is apparent that NRTA/AARP and other consumer-related groups need to provide adequate information to ensure optimal awareness on the part of beneficiaries. Because there are no resources in the proposed regulations for dissemination of information by constituent organizations, there may be less than maximum impact as aging organizations have limited funds for promotional efforts among their memberships and the broader older adult community. Nonetheless, aging organizations represent one of the most effective avenues for creating consumer awareness of the new Medigap regulations.

While consumer awareness can be heightened and greater sensitivity achieved by older persons in selecting supplemental policies, the consistency of information on a comparison basis must be mandated if the dissemination process is to be fruitful. It is imperative that the federal and state agencies responsible for administering the program establish clear-cut requirements for policies in order to facilitate effective comparison shopping. In addition, these requirements must be policed or consumer awareness efforts will be hollow.

During 1981 NRTA/AARP included a program on supplemental health insurance in its nationwide series of six Issue Forums. Presentations were made by HCFA representatives and Association staff familiar with the implications of the new law. These sessions met with a positive response from over 2,000 older adult participants who were concerned over how to save their limited health care dollars. They were excited about the potential impact of PL 96-265. This is indicative of the broader interest that older adults have in maximizing their insurance dollars. Many are concerned that they are paying too much for supplemental health insurance, and they want to redress this problem. Establishment of basic standards and approaches are critical in assisting older persons to make cost-efficient comparisons. PL 96-265 has this potential—if it is implemented and promoted effectively.

Because the program is voluntary there is potential for abuse. If this does occur, it is the beneficiaries who will suffer, as well as the new system. It would have no credibility among those it is designed to serve. Consideration should be given to including a survey of consumer satisfaction with the system as a part of the annual report to Congress. This is one of the keys to determining the impact and utility of the proposed law. If, over time, there is a significant decrease in consumer satisfaction, Congress should consider the imposition of a mandatory certification process with set standards for comparison.

The Future of the Voluntary Certification Program

Given the current mood of the public, as well as the political sensitivities of the Reagan Administration and Congress, it would seem that mandatory or highly prescribed standards of conduct are not likely to be imposed on any industry. This only increases the need for effective implementation of the VCP, as this may represent a test of how responsive private industry is to voluntary regulatory programs in general. It therefore behooves the insurance industry to make the VCP a useful, standardized system of consumer awareness.

There is a major philosophical and political predisposition in our nation today to emphasize an individual's responsibility to make decisions affecting his/her own welfare. While the concept is sound, in many cases it places an unfair burden on consumers who are receiving inadequate or unreliable information as the basis for their decisions. It is government's responsibility to ensure the accuracy of consumer information.

While it is recognized that there must be ample time for the certification system to function smoothly, there must be ongoing monitoring of the program's effectiveness, both in terms of the responsiveness of insurers and the interest and support of beneficiaries. The possibility of mandatory regulations, if the VCP breaks down, should be maintained as a real and viable alternative (incentive). There must be adequate enforcement measures developed to ensure compliance with the current system. Once faith in the system is lost, the VCP will be useless.

Congress must annually review the program's impact in order to determine proper strategies for either strengthening or somehow modifying the law. Clearly, the federal government established only minimum standards for Medigap policies. If states accept only these minimum standards, without creating and enforcing their own stronger laws, Congress may soon again need to take action of a mandatory nature.

Our Associations endorse the concept of the VCP, and seek for it to become an effective tool for consumer use in making viable policy comparisons. If this system does not work effectively, it remains for Congress and the public to consider a mandatory system that will provide the type of information and assistance that Medicare beneficiaries need to make informed decisions about how their health insurance dollars can best be spent.

THE HEALTH INSURERS' VIEW
As Represented by Blue Cross/ Blue Shield Associations

The Voluntary Certification Program as an Appropriate Response to the Problems of the Elderly

During the 1970s several Congressional hearings and staff studies documented egregious abuse of the elderly by a few insurance companies and their salesmen. The reports and hearings were largely produced by advocates of a new role for the federal government in regulating the marketing and content of Medigap policies.

The picture presented for legislative attention was not as balanced as the health insurance field would have preferred. It was not established how widespread the abuses really are because the advocates concentrated primarily on the presentation of a succession of dramatic but isolated horror stories. While a convincing case was made for legislative reform, we felt that in the process Blue Cross and Blue Shield Plans—none of whom were in any way implicated—and most commercial insurance companies as well, were being splattered with a reformist's brush that should have been applied more selectively to those few bad actors responsible for the Medigap problems.

We also were unenthusiastic about the proposed intervention of the federal government into the regulation of insurance—an area which heretofore has been, almost exclusively, the domain of state government. Nevertheless, we did not oppose enactment in 1980 of the Baucus Amendment because, while we knew that, inevitably, we would be burdened by the solution to a set of problems for which we were not responsible, we felt the best interests of the elderly demanded that we not obstruct that solution.

Is the Baucus Amendment a good approach to dealing with those problems? It will take a few years to tell. It was a compromise measure impacted by the varying points of view of the Senators and Representatives who enacted it and by the expressed interests of consumer groups, insurers, and state insurance regulators. It represents a politically practicable attempt by the Congress to set some product standards and deal with unfair marketing and claims practices. Probably none of those involved would claim that the resulting legislation is the optimum design.

The concept of voluntary certification of insurance policies as a competitive marketplace-oriented strategy has a good deal of appeal. But the Baucus Amendment is much more than that. To refer to the amendment as a voluntary certification program is really a mischaracterization. The proposal did begin in that form, but when the measure was debated in the Senate, it was modified to provide that states have until mid-1982 to establish Medigap regulatory programs on their own. As a minimum, those programs must conform to the model Medigap regulation which was adopted by the National Association of Insurance Commissioners (NAIC) in June of 1979 as part of its suggested regulation to implement the NAIC Individual Accident and Sickness Insurance Minimum Standards Act. If states implement their own programs meeting that standard, Medigap policies in those

states will be deemed to be certified by the federal government and the federal program of voluntary certification actually will not go into effect in their jurisdictions. Whether state programs meet the NAIC standards is to be determined by a Supplemental Health Insurance Panel (SHIP) composed of the Secretary of Health and Human Services and four state insurance commissioners appointed by the President. We understand that 43 states have expressed the intent to implement programs that will qualify for exemption from the federal program. Thus, the Baucus Amendment, as enacted, is really a program of regulatory standards for the states to follow, with a stand-by voluntary federal certification plan to cover those states which fail to act. The coercive element motivating state action is the spectre of having the federal government set up a certification program which, arguably, would serve as a wedge which proponents of a greater federal role in insurance regulation could use in the future to expand the federal role in Medigap as well as other areas of insurance.

Strengths, Weaknesses and Problems of the Voluntary Certification Program

The Double Standard

The federal Voluntary Certification Program is very different from the mandatory state regulatory schemes which must be implemented to keep the federal program from going into effect. We wonder whether the Congress understood that that would be the case. Certainly, there is nothing explicit in the legislative history to indicate it.

Under the federal program, insurers who wish to market Medigap policies bearing the HHS "seal of approval" must meet benefit and loss ratio criteria and follow the marketing practices dictated by the NAIC model regulation. But federal certification is a strictly voluntary procedure and the Baucus Amendment does nothing to prevent insurers from marketing whatever kinds of noncomplying coverage a state may otherwise allow, labeling and selling those coverages as Medicare supplements if the state permits, but refraining from asking HHS to certify them.

On the other hand, the SHIP considered the issue of whether state Medigap regulatory programs can be exempted from the federal VCP if they permit the sale of policies which complement Medicare benefits but do not meet the NAIC benefit standard, even if those policies are clearly labeled and sold as not qualifying for the label "Medicare supplement." At least two Commissioners on the Panel appeared to feel that the sale of such policies should not be allowed if the state is to qualify for exemption. Without going into the legal arguments for and against this interpretation, suffice it to say that if such policies were banned from the market the result would be that the Baucus Amendment has created a double regulatory standard—a very permissive program for federal certification and a much more restrictive one for states to implement. Did Congress truly intend this result when the NAIC model regulation was incorporated by reference into the Baucus Amendment? We find nothing in the legislative history to indicate that the general intent of the Congress was other than that states would have the opportunity to implement programs of their own, which, at a minimum, though not voluntary in nature, would generally be equal to the federal program—and that both federal and state programs would be based on the NAIC model regulation.

In deciding the issue the Panel limited its ruling to a single statement that it

will "approve a state's program only if it contains marketing restrictions concerning the sale of Medicare supplements equal to or more stringent than the NAIC model." We think this was a wise decision. It allows states the leeway, under exempted regulatory programs, to permit some desirable variation in the design and price of health benefits offered for sale to the elderly but under stringent rules which will preclude misrepresentations of the product or other abuses contrary to the spirit of the Baucus Amendment.

Use of Loss Ratios

While the draft provisions of the HHS regulation dealing with loss ratios present technical difficulties for Blue Cross and Blue Shield Plans, we believe that the requirement that loss ratios be disclosed to prospective purchasers of Medigap insurance is one of the most important and salutory provisions of the Baucus Amendment. Consumers may continue to be confused by differences in benefits between competing policies but if they know that one policy, on the average, returns ninety cents in benefits for every dollar of premium paid in while another returns seventy cents for each dollar, they at least know which one is the best buy. We are concerned however that the minimum loss ratio standards of 60 percent for individual policies and 75 percent for those group coverages which fall under the Act may prove to be too low. We wish that Congress had set a higher standard for insurers to meet—one that would have guaranteed the elderly a higher return for their insurance dollars.

Applicability of the Baucus Amendment to all Medicare Eligibles

HHS and the Panel have disagreed on the issue of whether the Baucus Amendment should be deemed to require that the NAIC model standards be applied to the marketing of Medicare supplements to all persons eligible for Medicare or only to those eligible for Medicare by reason of age. The Panel has taken the position that for purposes of evaluating state programs it will concern itself only with the application of the regulations to persons eligible by reason of age because that was clearly the intent of the NAIC model. We think the Panel's approach is reasonable and appropriate. It makes little sense, in our view, to apply the standards when they would produce little if any actual benefit for Medicare beneficiaries under 65. Many insurers do not offer coverage to that group and nothing in the Baucus Amendment or the NAIC model regulations would require them to do so. If the SHIP ruled that all health insurance designed to complement Medicare must meet the NAIC standard, the result of bringing the under-65s under the aegis of the state regulations might well be that those relatively few insurers that do offer them coverage would discontinue it rather than comply with the required benefit standards for this particularly high risk population.

Problems Relating to the NAIC Minimum Standards

For some Blue Cross and Blue Shield Plans the NAIC minimum standard benefit package presents special problems. Their inclination would be to simply add whatever benefits are needed to their existing Medigap policies, but those Plans are already losing money on their Medigap programs and are unable to obtain approval from their state insurance commissioners for the higher premiums needed to finance the expanded benefits. In states which fall under the federal voluntary certification program, Plans may choose to simply continue marketing their current benefits and go without whatever competitive advantage the HHS

seal of approval might have afforded them. On the other hand, in states exempted from the federal program—if the SHIP had ruled that wraparound policies not meeting the NAIC benefit standard cannot be sold—such Plans will be forced to lower the levels of front-end coverage they now provide in order to produce the financial wherewithal to include the NAIC model's catastrophic benefits.

Front-end coverage is becoming increasingly important to our Medigap subscribers. For 1982, the Congress has imposed an additional $350 million in cost sharing on Medicare beneficiaries. The Part A deductible, for example, due to a change in the way it is calculated, will jump from $180 to $260. We expect that this unfortunate government strategy of transferring program costs to out-of-pocket payers and insurers will produce similar cost sharing increases in future years.

Some theorists urge that if the elderly must pay the Medicare deductibles out-of-pocket they will use less health care. We don't doubt it. The problem of course is that no one can show that the treatment the elderly may forego is unnecessary care. In fact, going without early diagnosis and treatment due to cost considerations often leads to a more expensive and longer course of treatment later due to deterioration in the patient's condition.

Another problem derives from the fact that the NAIC model requires that insurers who offer benefits covering cost sharing amounts under Medicare *must* increase those coverages automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. It does not, however, provide that premiums must be permitted to increase commensurately to adjust for the additional liability. Unlike commercial insurers, Blue Cross and Blue Shield Medigap premiums are subject to prior approval by state insurance regulators. Several Plans—based upon their previous experience—expect that they may find themselves increasing their benefit levels and having their insurance commissioners refuse to grant the rate increase needed to cover the added claims expense. While our Plans operate on a nonprofit basis, they cannot afford to provide coverage at a loss for long. Losses incurred under the Medigap line of business must be subsidized by other non-Medigap subscribers. This soon leads to higher rates for all subscribers and puts Blue Cross and Blue Shield Plans in a noncompetitive position in the health insurance marketplace.

The Role of the Supplemental Health Insurance Panel

We believe the independent role which the SHIP has established for itself is an appropriate one. It appears clear to us that Congress intended the Secretary of HHS to chair the panel but that it did not intend the panel to be merely an advisor to the Department or to be subject to regulation by the department. With respect to the interpretation of the NAIC standards as they apply to the determination of whether state regulatory programs qualify for exemption, the Panel should have full control. The Secretary has one vote in that process. Four insurance commissioners appointed by the President each have a vote, also. This arrangement is consistent with the expressed Congressional intent not to interfere with state regulation of insurance

The Impact of the Baucus Amendment on Consumers, Insurers, and Regulators

As mentioned at the outset, the Baucus Amendment can hardly be regarded as an ideal model by any of the groups involved, but for consumers it certainly

should improve the operation of the market for Medigap insurance which existed in many states prior to its enactment.

In states subject to the VCP, consumers will know that certified policies bearing the HHS seal of approval meet minimum government standards for policy content and loss ratios. In exempted states, they will be assured that any product labeled "Medicare supplement" meets the same standards. In all states they are protected from unscrupulous sales practices.

Not all insurance commissioners welcome even the modest federal intrusion into their jurisdiction which the Baucus Amendment represents. But one provision of the law should assist them considerably. Many commissioners have expressed frustration over their inability to deal effectively with mail order Medigap insurers. The Baucus Amendment imposes a federal criminal penalty of $25,000 and/or up to 5 years imprisonment for the use of the mails to deliver into a state a Medigap policy not approved by that state's insurance commissioner. It also establishes criminal penalties for certain sales misrepresentations. These provisions should enhance the commissioners' abilities to effectively protect elderly purchasers of Medigap insurance. In addition, the threat of having a federal insurance certification program—albeit a voluntary one—go into effect in their state, coupled with the desire of many insurers to keep that from happening, may make some state legislatures more willing to enact whatever laws are necessary to authorize a state Medigap regulatory program meeting the NAIC minimum standard.

Implementation of the Baucus Amendment may drive some marginal insurers from the Medigap marketplace. If that, in fact, happens both consumers and those insurers that remain will benefit. The law does create additional costs and administrative burdens for insurers, but compliance with the new requirements will guarantee consumers that the Medicare supplements they purchase meet at least minimum product standards. It also may enhance the reputation of those insurers still willing to provide Medigap insurance—if only because they will no longer be associated in the public mind with the few unscrupulous companies and salesmen whose unethical practices have tended to compromise the reputations of all competitors in the Medigap marketplace.

Medigap as a Model for Further Competition-Oriented Reforms

At Congressional hearings on National Health Insurance, our Associations have testified that the regulation of health insurance under NHI is a matter best left in the hands of the states, subject to broad federal guidelines and standards of performance. The same position should be equally applicable to Medigap insurance and to any federal pro-competition measure which might become law in the foreseeable future. The legislative challenge is for the federal government to establish meaningful measurements of adequate state regulation and not fall into the trap of being overly prescriptive about the details of getting the job done—a trap the federal bureaucracy has often fallen into in the past. There must also be some element—whether carrot or stick—which serves as an inducement for the states to act in conformance with national policy. In the case of the Baucus Amendment the motivation is provided by the threat of mild federal intervention

into the states' jurisdiction over insurance. Rather than follow precisely the precedent set by the Baucus Amendment, future federal legislation dealing with insurance might adopt a scheme similar to that unsuccessfully proposed in the 94th and 95th Congresses for no-fault auto insurance; i.e., a model minimum program for states to enact and a more stringent, rather than more lenient, federal stand-by regulation program that would go into effect only in those states which fail to comply. That model also might logically be turned to by the Congress should it decide to "voucher out" the Medicare program, a possibility currently being explored by Reagan Administration policymakers.

It is too early to tell whether the Baucus Amendment can be judged a success. Many of the problems and ambiguities federal and state officials and insurers are currently struggling with will doubtless be resolved as state regulations are implemented and the VCP goes into effect over the next year.

In retrospect, we believe that despite the years of hearings and advocacy of reforms, the Congress acted precipitously in its passage of this measure. Had more time been taken to construct the program in consultation with state governments as well as the insurance industry, a better design probably would have resulted.

We believe the best course for the Congress to have taken would have been that approved in 1979 by the Health Subcommittee of the House Committee on Energy and Commerce; i.e., enact the criminal provisions immediately but delay establishing the rest of what is contained in the Baucus Amendment until a more thorough study of the issues and the pros and cons of various solutions could be performed and a more carefully constructed program put together.

THE HEALTH INSURERS' VIEW
As Represented by
the Health Insurance Association of America

Confusion about the federal Medicare program, its complicated benefit structure, coinsurance provisions, deductibles and exclusions has made it especially difficult for elderly citizens to evaluate their health insurance needs. This confusion, together with misunderstanding of the various kinds of private health insurance available, has contributed substantially to the vulnerability of the elderly to unethical sales practices. State insurance department investigations, Federal Trade Commission studies, and congressional inquiries have revealed special problems which the elderly experience in purchasing private insurance to supplement their Medicare coverage. Although no evidence has been presented that abusive tactics are widespread, a number of egregious incidents, usually involving "stacking" of policies (i.e., selling a number of policies to a single individual, thus providing duplicate, often inadequate, coverage at very high cost) have emphasized the need for remedial action.

In recognition of these concerns, the health insurance industry through its principal trade association, the Health Insurance Association of America, formed a task force to review insurance policy benefit design and to consider methods to enhance consumer understanding of Medicare and of private insurance. The HIAA developed and published an easy-to-read explanation of health insurance products for senior citizens entitled "What You Should Know About Health Insurance When You Retire." Member companies were requested to review their own procedures relating to insurance coverage of senior citizens. HIAA also coordinated with agent organizations to address the question of unethical sales practice and urged the National Association of Insurance Commissioners to establish a task force to study the adequacy of current regulation and develop new model standards if necessary. During this time, the HIAA testified before congressional bodies studying the issues and recommended national acceptance of state-by-state solutions.

In 1978 the NAIC appointed a task force of six state commissioners to study the issue and propose solutions. The task force was assisted in its work by an advisory committee which was composed of representatives of the federal government, consumer and senior citizen groups, and the health insurance industry, including the HIAA. The task force recommended amendments to the "NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act," which would establish a special category of "Medicare supplement" coverage. The amendments, adopted by the NAIC in June of 1979, provide that all Medicare supplement policies, defined as policies designed primarily to supplement Medicare or advertised, marketed, or otherwise purported to be a supplement to Medicare, must contain specified minimum benefits. Insurers would be required to deliver an outline of coverage with each Medicare supplement policy, and to identify certain limited benefit type policies sold to the elderly, such as hospital indemnity or cancer insurance policies, with a caption clearly stating that they are not Medicare supplement policies. Insurers would also

be required to deliver to senior citizens in conjunction with the sale of any kind of health insurance a copy of a buyers' guide. The NAIC in cooperation with DHHS prepared a buyers' guide entitled "Guide to Health Insurance for People with Medicare" which has been widely distributed and which has become the guide usually required for distribution in states which have adopted the NAIC standards.

Independent of NAIC activity, various state insurance departments were pursuing their own administrative solutions to the medicare supplement problem as it manifested itself in their individual states. As of December 31, 1979, according to an NAIC report, 19 states had enacted specific laws or regulations to combat fraud and abuse associated with Medicare supplement policies, and 7 more had regulations under consideration. In addition, administrative or criminal proceedings had been initiated under existing state laws against persons engaging in abusive practices.

In spite of this activity, several Congressmen, among them Senator Max Baucus (D-Mont.), asserted that the states themselves had been slow in taking corrective action and that it was necessary for Congress to step in. It was the position of the HIAA that this assertion failed to recognize both the progress that had been made up to that date and the willingness and ability of each state to proceed as necessary and appropriate for its special circumstances. We opposed the prospect of federal action as unnecessary and unwise, as well as inconsistent with the interest of the public in reducing the intrusion of the federal government in the lives of individuals and in the economy.

In the two years that have elapsed since PL 96-265 was enacted, the evidence continues to support our position. There is no better indicator of the states' willingness and ability to act than their response to the federal law. Nearly every state has already adopted or is in the process of adopting standards governing the sale of Medicare supplement insurance. While it is true that several of these states may not gain approval from the Supplemental Health Insurance Panel because their standards are not strictly in compliance with the federal law, this in no way diminishes the significance of their actions. States such as New York or California or Wyoming are technically "deficient" under the federal standards only because they strongly believe that their own comprehensive regulatory remedy is better for the citizens of their states. They have not abdicated their responsibilities; on the contrary, they have exercised them to the fullest.

The vast majority of the states will have an approved program in place before the July 1 target date for implementation of the certification procedure. This means that the entire bureaucratic effort constructed, maintained, and financed for the purpose of reviewing forms to be issued in nonapproved states will achieve little, if anything, for the benefit of senior citizens. Even in those nonapproved states, extensive Medicare supplement regulations will be enforced by state insurance departments, independent of any federal activity. Federal certification indicating that policies meet federal standards which are different from state standards will not offer any additional protection to residents of those states, but will present considerable opportunity for confusion.

It has been the position of the HIAA since the federal certification concept was first proposed that it has enormous potential for mischief. Even now, when many in the industry have lived with the concept for over two years, and even

among those most familiar with PL 96-265 and state Medicare supplement regulation, there remains substantial disagreement over the exact nature of certification and what it will signify. The difficulties multiply when one begins to consider the procedures for recertification and decertification and what effects they will have in the marketplace. It will be virtually impossible for senior citizens to understand why a policy may be certified in one state but the identical policy would not be certified in another state; or why a noncertified policy may in fact be a better product than a certified policy; or why a policy which had been certified is no longer certified, even though the policy benefits have not changed; or why it may be contrary to their best interests to replace their existing noncertified policy with a new certified policy. As a guide for senior citizens, federal certification is likely to prove woefully counterproductive.

PL 96-265 suffers from another very serious flaw: it immortalizes the NAIC minimum standards for Medicare supplement insurance as they were adopted in 1979. Thus amendments to the 1979 standards which in light of new and developing circumstances and additional study may prove to be beneficial, if not essential, are effectively prohibited. This is particularly disturbing in the current economic situation where drastic changes in the Medicare program are being discussed. Some proposals would alter the very structure of the program, rendering the NAIC standards totally meaningless.

There are more fundamental problems with PL 96-265 that go beyond discussions of concepts. The statute itself is riddled with inconsistencies, inaccuracies, definitions which are contradictions in terms, and a total disregard for the realities both of the insurance marketplace and of the nature of state regulation of insurance. As a result there are a number of very important provisions which are utterly mystifying as to their intention and effect. The confusion of senior citizens about certification of policies may be exceeded only by the questions which insurers and state regulators alike will have about their rights and obligations under this law.

In the face of all these complications, the cooperation among the states, the industry and the federal government in trying to make the best of a very difficult situation has been impressive. We would like to thank the state insurance departments for their efforts in expediting the administrative and legislative procedures necessary to establish approved regulatory programs in their states. We would also like to express our appreciation to staff of the Health Care Financing Administration for their cooperation and assistance. Unfavorable circumstances notwithstanding, it has no doubt been an instructive experience for all.

CHAPTER IV

Summaries of State Regulation of Medicare Supplements

SUMMARY OF STATE REGULATIONS OF MEDICARE SUPPLEMENTS

by
Donna B. Potemken

Alabama

Act 81-560, entitled "Alabama Medicare Supplement Minimum Standards Act" is the enabling legislation for the sale and content of Medicare supplement policies in the state. The law contains policy and disclosure standards. The Commissioner of Insurance is authorized to issue regulations establishing minimum benefits and loss ratios. The effective date of this law was January 1, 1982.

The Alabama Department of Insurance developed Regulation No. 71, which implements the law. This regulation follows the NAIC Model Medicare Supplement Regulation. Loss ratios are set at 75 percent for group and 60 percent for individual policies. Alabama also requires use of the HCFA/NAIC buyer's guide. The effective date for this regulation was January 1, 1982.

The Supplemental Health Insurance Panel (SHIP) reviewed Alabama's program and granted it approved status on October 19, 1981.

Alaska

Alaska SB 43, which became effective September 23, 1981, sets minimum standards for the sale and content of Medicare supplement policies. Regulations have been drafted outlining the Medicare supplement minimum standards, loss ratios and disclosure provisions. Hearings on the regulations took place in mid-August. Alaska is in full compliance with the provisions of the Baucus Amendment.

Arizona

HB 2187 of the 1981 Arizona legislative session authorizes the Director of the Department of Insurance to adopt rules relating to Medicare supplement insurance, which are necessary to comply with the Baucus Amendment.

R4-14-606, entitled "Medicare Supplement Insurance Disclosure and Minimum Standards" was originally adopted by the Department of Insurance May 20, 1980. The rule was amended and then certified by the Attorney General on February 2, 1981. It became effective June 1, 1981. Several subsections of R4-14-606 were amended again and became effective January 1, 1982.

The amendments include:

- the definition of a "benefit period;"
- a six-month or less preexisting condition limitation;
- deletion of the portion of the Rule which allows the separate sale of a Part B only Medicare supplement policy;
- addition of a section regulating the required disclosure of riders and endorsements.

The Arizona regulatory program was reviewed on September 16, 1981, by the SHIP and conditionally approved. The deficiency at that time was that the replacement requirements only applied to individual policies. The requirement was expanded to cover all Medicare supplement policies. On November 23, 1981,

the SHIP reviewed the program again, changing its conditional approval to approval.

Arkansas

Arkansas has enacted enabling legislation which encompasses minimum standards, loss ratios, disclosure and the advertising of Medicare supplement policies. Regulation 27, which became effective August 1, 1981, implements the enabling legislation.

Regulation 27 contains detailed requirements for minimum policy standards and disclosure provisions. It also establishes requirements for replacement of an individual Medicare supplement policy. The SHIP approved Arkansas' regulation on June 26, 1981.

California*

California has established minimum standards for Medicare supplement, specified disease and hospital indemnity policies. The state has set three classes of Medicare supplement coverage: in-hospital expenses only, in-and-out-of hospital expenses, and catastrophic.

AB 2947 of the 1980 regular legislative session requires that Medigap policies meet minimum benefit standards established jointly by the Commissioners of Insurance and Corporations. The law also states that reinsurance policies and plans must have a 30-day free-look period. These policies cannot be limited to specific disease coverage. The two commissioners are also required to provide a buyer's guide which health insurers shall distribute to potential purchasers of policies at the time of initial contact. The Department of Insurance published a buyer's guide in October 1980 entitled "Buyer's Guide to Medicare Supplement Insurance for Californians."

AB 1807 of the 1981 regular session relieved the Commissioner of Corporations of joint responsibility to set minimum benefit standards. This law defines "Insurance policies to supplement Medicare" to include disability insurance policies and nonprofit hospital service plan contracts designed to supplement Medicare. AB 1807 requires the Insurance Commissioner to promulgate regulations establishing:

- prohibited policy provisions;
- minimum loss ratios;
- the contents of an informational brochure; and
- disclosure standards.

Blue Cross in California is regulated by the Department of Insurance but Blue Shield is regulated by the Department of Corporations. Amendments to the Knox-Keene Health Care Service Plan Act of 1975 cover disclosure standards for policies and plans which are covered by the Department of Corporations.

The SHIP reviewed California's regulatory program November 23, 1981, and noted the following shortcomings:

- failure of the outline of coverage requirements to follow the NAIC model format;
- lack of replacement requirements;
- allows the sale of catastrophic Medicare supplement policies which do not follow the minimum benefit requirements; and
- no jurisdiction over Blue Shield plans.

* States with an * were reviewed by the SHIP on June 9, 1982. Changes will be noted in the addendum at the end of this chapter.

The SHIP said that additional documentation relating to Blue Shield was required. The Department of Corporations subsequently submitted proposed changes to the rules under the Knox-Keene Act.

California's program was reviewed again on December 17, 1981, at which time state officials announced their unwillingness to change the part of the legislation which deals with catastrophic Medicare supplement policies. SHIP then issued its advisory opinion that California would not be in compliance by July 1, 1982.

In 1982 the Department of Insurance plans to adopt rules that would be the equivalent of the full NAIC standards. A notice of hearing was announced in mid-April concerning the regulations. The Department anticipates that the regulations will become effective July 15, 1982.

Colorado

The state of Colorado has regulated the sale of Medicare supplement insurance policies since 1977. Regulation 76-6 establishes disclosure requirements for the sale of Medicare supplement and hospital indemnity policies. It applies only to individual policies, not to group plans or to out-of-state direct response insurers. The effective date for this regulation was July 1, 1977.

In 1978, three laws were enacted which affected the sale of Medicare supplement policies in the state. HB 1100 authorized the Commissioner of Insurance to establish minimum loss ratios for Medicare supplement policies. HB 1004 established a standard definition for the term "Medicare Supplemental Policy." The legislation also concerned unfair practices in the sale of these policies, and called for a standard disclosure form and a 30-day offer of rescission with no obligation on the part of the insured.

Regulations were promulgated to implement HB 1004 and HB 1100. Regulation 78-1 implemented HB 1100, and established a 60 percent minimum loss ratio for Medicare supplement policies. The effective date for Regulation 78-1 was June 11, 1979. Regulation 78-2 implemented HB 1004, and requires that a disclosure form be delivered to the insured when making each Medicare supplement policy sale. The effective date was June 11, 1979.

The third law passed in the 1978 session, HB 1101, called for development of a training program for persons working with the elderly on a local level to assist them in dealing with Medicare supplement insurance problems. Materials for this program were developed by the Office of the Commissioner of Insurance and Metropolitan State College in Denver. They are entitled "What You Should Know About Medicare and Supplemental Medicare Insurance: A Consumer's Guide for Senior Citizens," and "Health Care Financing for the Elderly."

In 1981 Colorado enacted HB 1256 which regulates Medicare supplement policies further. It set loss ratio standards at 75 percent for group and 60 percent for individual policies. The legislation authorizes the Commissioner of Insurance to issue reasonable regulations to establish standards for disclosure provisions, minimum standards for benefits, and to prescribe the format and context for an outline of coverage.

Regulation 81-1 was promulgated as a result of HB 1256. The effective date was January 1, 1982. These regulations include prohibited policy provisions, minimum benefit standards, loss ratio standards, readability and disclosure standards.

The SHIP reviewed Colorado's program on October 19, 1981, and determined that it complied with the NAIC model. In several areas it was more strict than the model. These areas are: 30-day free look for policies sold by an agent as well as direct response policies and additional disclosure requirements with regard to nursing home benefits and outline of coverage.

Connecticut *

Public Act 79-289 of the Connecticut General Assembly authorizes the Commissioner of Insurance to establish specific disclosure standards. The law sets loss ratios at 65 percent for individual and 70 percent for group policies. The legislation applies to any Medicare supplement policy delivered or issued for delivery on or after October 1, 1979.

Administrative Regulation 38-174, effective April 7, 1981, was promulgated as a result of PA 79-289. It is entitled "Disclosure Requirements for Medicare Supplement Policies and Policies which Duplicate Medicare Benefits," and establishes specific disclosure standards in the sale of insurance contracts that supplement or duplicate federal Medicare insurance.

PA 81-79, effective October 1, 1981, amended Administrative Regulation 38-174 to conform to the Baucus Amendment. The loss ratio was changed to 75 percent for group policies. There are now four standards for loss ratios in Connecticut:

- 65 percent for all individual policies sold to state residents eligible for Medicare;
- 65 percent for all individual Medicare supplement policies;
- 70 percent for all group policies or certificates delivered to residents eligible for Medicare; and
- 75 percent for any group Medicare supplement policy as defined by the Baucus Amendment.

The SHIP conditionally approved Connecticut's program on November 23, 1981, noting the following deficiencies:

- the lack of the required definitions of benefit period, accident, physician, nurse, skilled nursing facility, and sickness;
- the lack of a requirement that coverage extend for an additional 365 days of confinement at 90 percent after expiration of the Medicare lifetime reserve days;
- no requirement for a Buyer's Guide; and
- failure of the replacement requirement, free-look provision, and outline of coverage to comply with the NAIC model.

Regulations have been proposed to amend Administrative Regulation 38-174 to correct the above deficiencies. The regulation is awaiting the signature of the Secretary of State.

Delaware *

HB 547 has been introduced into the House of Representatives in Delaware. The bill includes definitions of the terms: applicant, certificate, Medicare supplement policy, and Medicare. HB 547 also describes disclosure standards and notice of free examination. The legislation if enacted would authorize the Commissioner to issue regulations to establish specific standards for policy provisions, minimum benefits, and loss ratios. The regulation is in draft form. A formal public hearing on the regulations will be scheduled after the bill is enacted. Delaware is expected to be in compliance by July 1, 1982.

Florida

The basic Medigap legislation in Florida is sections 627.671-627.675 of the Florida Statutes, which is the "Florida Medicare Supplement Reform Act," effective January 1, 1981. It states that the Commissioner shall issue rules which, together with the new law, will be no less comprehensive than the NAIC model. Loss ratio standards are 60 percent individual and 75 percent group. It also outlines the minimum benefits, limits the waiting period for preexisting conditions to six months, and requires delivery of a Buyer's Guide (NAIC-HCFA) at the time of application (with the limitations in the NAIC model) as well as an outline of coverage in the prescribed NAIC form. It requires that the policy contain a prominently displayed "no loss cancellation clause" with a 30-day free look period. It further requires that outlines of coverage delivered in conjunction with individual policies of hospital confinement, indemnity insurance, specific disease insurance, specified accident insurance and supplemental disability insurance contain the following language on the first page: "This policy is NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Medicare Buyer's Guide available from the company."

Chapter 4-51 of the rules of the Department of Insurance, "Requirements of Medicare Supplement Insurance" became effective January 1, 1981. These rules conform with the NAIC model, with the exception that applicability is to out-of-state, as well as in-state group policies and certificates.

The laws and regulations of Florida were reviewed by the SHIP on June 26 and September 16, 1981. The state regulatory program was approved.

Georgia

There are two pieces of enabling legislation in Georgia, both passed in 1980.

SB 451 (Act 1301, Laws of 1980) became effective November 1, 1980. It adds a section to the Georgia Insurance Code, designated 56-3019, Medicare Supplement Health Insurance. It requires that Medigap policies provide "reasonable benefits...in relation to the premium paid," but does not specify loss ratios. It also empowers the Commissioner of Insurance to adopt rules and regulations covering waiting periods, exclusions, reductions, preexisting limitations, readability and advertising.

It further amends the Code by adding sec. 56-704 covering deceptive acts or practices in the sale of Medigap policies. These include:

- knowingly selling duplicative coverage;
- representing that any policy, insurer or agent is endorsed or sponsored by any group when such is not the case; and
- knowingly selling to Medicaid recipients coverage which duplicates benefits provided under the Medicaid program.

A third section provides grounds for disapproval of forms. These include:

- inconsistent, ambiguous or misleading language;
- printing which is not legible to persons of normal vision;
- unfair or inequitable provisions; and
- benefits which are unreasonable in relation to the premium charged.

HB 1439 (Act 1340, Laws of 1980), effective April 1, 1980, empowers the Insurance Commissioner to adopt rules and regulations covering Medigap standards

as discussed in SB 451. Additionally, it mandates that the Commissioner develop a uniform disclosure statement for use in the sale of all Medigap policies.

Regulations which were developed as a result of this legislation are included in Chapter 120-2-8 of Georgia's Rules and Regulations. They became effective November 1, 1980, and generally conform with the NAIC model, with the following exceptions:

- Exclude hospital indemnity policies, specified disease, and limited accident policies from the definition of Medicare supplement insurance;
- Require that Medicare Part A deductible be offered as a minimum benefit and that other minimum benefits conform to the model requirement;
- Do not use the NAIC model outline of coverage; however, the requirements are substantially the same as those in the model, except that the Georgia outline must contain a statement about the availability of coverage for the Medicare Part A deductible as an option.
- Have a special disclosure provision that each agent must complete a special "certification form" in which the agent comfirms that he/she has fulfilled the requirements of the regulations with respect to explanation of benefits, determination of other existing policies held and so forth;
- Require that applications ask whether the applicant holds a current Medicaid eligibility card. Provides that no Medicare supplement policy shall be issued to anyone who has a current Medicaid eligibility card.

The SHIP approved the Georgia program on September 16, 1981.

Hawaii *

The state of Hawaii enacted SB 1713 regulating the sale and content of Medicare supplement policies effective June 8, 1981. SB 1713 (Act 104) includes definitions relating to insurance, standards for policy provisions and disclosure standards. The Commissioner of Insurance is authorized to issue reasonable rules establishing minimum standards for benefits and loss ratios, and additional rules for disclosure standards.

The proposed regulation, Title 16, Chapter 12, of the Department of Regulatory Agencies, follows the NAIC model. The regulations define terms relating to prohibited policy provisions, and minimum benefits and disclosure standards. Minimum loss ratios are set at 75 percent for group and 60 percent for individual policies.

The SHIP reviewed Hawaii's program and granted it conditional approval pending finalization of the state's regulation, which is expected before July 1, 1982.

Idaho *

SB 1078 adds Chapter 44, Title 41, to the Idaho Code. It provides the legislative base for regulating Medicare supplement policies, effective July 1, 1981.

The law generally enables the Director of the Department of Insurance to issue regulations which establish standards for the sale of such policies.

The legislation contains a number of specific provisions:

- It defines a "Medicare Supplement Policy" as one "designated principally to

supplement Medicare or advertised, marketed or otherwise purported to be a supplement to Medicare."

- It establishes minimum loss ratios of 60 percent for individual and 75 percent for group policies.
- It provides for delivery of an outline of coverage at the time of application (except in the event the individual policy is issued on a basis other than that applied for).
- It provides that the director may prescribe by regulation that the Buyer's Guide be delivered to any prospective insured eligible for Medicare at the time of delivery after the outline of coverage.
- It limits the preexisting conditions period to six months.
- It contains the same free look provisions as the model—10 days in general; 30 days for a direct response solicitation.

The Idaho Department of Insurance Reg. No. 40—Medicare Supplement Insurance Minimum Standards—took effect May 1, 1982.

The provisions of the regulation generally conform with the model, except that Idaho offers a choice of Buyer's Guides—the NAIC/HCFA model and its own "Health Insurance Guide for Senior Citizens." It also exceeds the model in that it requires coverage of the Part A deductible.

The SHIP approved Idaho's program on November 23, 1981, pending finalization of the proposed regulations.

Note: A note at the end of SB 1078 indicates that it will expire one year after the Baucus Amendment is repealed or expires.

Illinois *

Public Act 80-435, effective October 1, 1977, established minimum standards for Medicare supplements. The statute dealt with minimum benefits, but also contained some disclosure provisions.

HB 3435, effective July 1, 1981, amends Sections 363 and 363a of the Illinois Insurance Code. It contains provisions related to minimum benefits and disclosure, provides for a 10-day free look, requires that coverage be nonduplicative, and that the agent be able to prove it. The agent is required to complete a "Policy Check List" at the time of solicitation.

SB 912, signed September 24, 1981, limits preexisting condition waiting periods to six months, broadens the free look period to 30 days for direct response solicitations, and prohibits the use of the terms "Medicare Supplement" and "Medigap" unless the policy meets the minimum standards.

At the time of the SHIP review, June 26, 1981, there were no specific regulations about Medicare supplement insurance. The panel decided to grant conditional approval based on the following deficiencies.

- Failure to include the definitions contained in the NAIC model.
- Does not limit or define the exclusions which can be imposed on a Medicare supplement policy.
- Requires coverage of only 20 percent of physician's charges rather than 20 percent of Medicare eligible expenses covered under Part B; also uses the term "benefit period" (undefined) rather than calendar year in conjunction with Part B.

- No restrictions on waivers which limit or reduce coverage for specified conditions.
- No prohibitions against reimbursing illness at a different rate than accidents.
- No prohibition on the use of the terms "Medicare Supplement," "Medigap," and other words of similar import.

Pursuant to that decision, on October 26, 1981, the Illinois Department of Insurance proposed a rule, Minimum Standards for Individual and Group Medicare Supplement Insurance, which corrects all of the above deficiencies.

On October 23, 1981, SHIP conditionally approved Illinois' program pending finalization of the rule.

Indiana *

Indiana's General Assembly enacted HB 1372, basic legislation on the sale and content of Medicare supplement insurance, March 3, 1980. The law authorizes the Department of Insurance to adopt a rule that provides for reasonable simplification of the terms and coverage of an individual Medicare supplement accident and sickness insurance policy, and an individual Medicare supplement subscriber contract. Another law, HB 1878, extends the department's authority to include group Medicare supplement accident and sickness, and group Medicare supplement subscriber contracts. This law went into effect September 1, 1981.

The Department of Insurance promulgated Reg. 31 as a result of HB 1372 and HB 1878. It basically follows the NAIC model, including minimum benefit, loss ratio, disclosure standards and requirements for replacement.

Indiana's regulatory program was conditionally approved by SHIP December 17, 1981, pending finalization of the regulation.

Iowa

Chapter 507 B of the Iowa Code regulates insurance trade practices. It defines unfair methods of competition and unfair or deceptive acts or practices and prohibits the sale of duplicative coverage. This chapter authorizes the Commissioner of Insurance to adopt rules which define the sale of duplicate Medicare supplement insurance.

The Uniform Individual Accident and Health Insurance Minimum Standards Act (Chapter 514 D) provides for reasonable standardization, simplification, and disclosure of the terms and coverages of such policies. This chapter took effect July 1, 1980. HB 768 of the 1981 legislative session requires the Commissioner of Insurance to adopt rules setting minimum standards for group Medicare supplement contracts.

Regulations implementing minimum standards for individual accident and sickness insurance and group Medicare supplement insurance were promulgated by the Department of Insurance. Chapter 510-36 basically follows the NAIC model regulation for individual policies. Loss ratio standards for individual contracts and policies are set at 70 percent. The regulation also defines coverage for specified disease coverage. Chapter 510-37 establishes minimum standards for group policies, setting the loss ratio at 75 percent. These regulations became effective December 31, 1981.

The SHIP received the Iowa regulatory program on October 19, 1981, and noted several deficiencies in the proposed regulations. The Iowa Department of Insurance made the necessary changes; the regulations were reviewed again on November 23, 1981, and approved.

Kansas

Kansas HB 2164 is the enabling legislation regarding sale of Medicare supplement policies. It authorizes the Commissioner of Insurance to adopt administrative regulations to satisfy the minimum standards of the Baucus Amendment.

KAR 40-4-35, effective May 1, 1982, adopts the December 1980 model regulation by reference. It includes provisions which are more strict than the NAIC model. Under the section relating to minimum benefits, the regulation includes coverage for Part A Medicare deductible and additional requirements for the outline of coverage requirement.

The SHIP approved the Kansas regulatory program October 19, 1981.

Kentucky *

HB179 authorizes the Commissioner to issue reasonable rules or regulations to establish minimum standards for Medicare supplement policies. This law became effective July 15, 1980.

Regulation 806 KAR 17:060 establishes such minimum standards for all individual policies, including a loss ratio of 65 percent. The regulation addresses prohibited policy provisions, required disclosure provisions and replacements.

Kentucky's regulatory program was conditionally approved by SHIP November 23, 1981, contingent upon the following defects being corrected:

- the lack of adequate authority over group contracts;
- no provision for the written receipt of the Buyer's Guide;
- no free look provision;
- the lack of a prohibition of preexisting conditions;
- loss ratio percentages for group contracts; and
- the lack of a prohibition of the use of the terms "Medicare supplement" or "Medigap" in connection with policies that do not meet minimum standards.

HB 86, effective February 26, 1981, corrects several of these deficiencies. It contains authority over group Medicare supplement policies and prohibits the terms "Medicare Supplement," and "Medigap" unless the policy meets the minimum standards. The law also includes a free look provision and requirements for preexisting conditions, and authorizes the Commissioner to issue loss ratio standards.

The Kentucky Department of Insurance has proposed amendments to 806 KAR 17:060. A public hearing was scheduled for May 3, 1982. The proposed amendments would become effective 30 days after a hearing is held by the Legislative Regulations Review Subcommittee.

Louisiana *

SB 965 is the basic enabling legislation for the sale of Medicare supplement policies. It authorizes the Commissioner of Insurance to issue reasonable regulations on minimum benefit and disclosure standards, and restrictions on prohibited

policy provisions. It sets loss ratios at 75 percent for group and 60 percent for individual policies, and defines certain terms in Medicare supplement policies. SB 965 became effective January 1, 1982.

The Department plans to implement SB 965 with the proposed regulations covering general policy provisions, minimum benefits and coverage.

The SHIP reviewed the program onDecember 17, 1981, noting several deficiencies: a loss ratio standard for group policies was not included; there were no instructions for delivery of replacement notice or for delivery of outline of coverage; there was no prohibition of use of such terms as "Medicare Supplement," and "Medigap;" and the terms hospital, physician, nurse and skilled nursing facility were not defined. The Louisiana program was conditionally approved, pending finalization of the proposed regulations.

Maine *

Maine passed enabling legislation (SB 175) on May 11, 1981. This law authorizes the Superintendent to establish minimum benefit standards for Medicare supplement policies and contracts. Loss ratios are set at 60 percent for individual and 75 percent for group policies. Disclosure standards also are outlined.

The Maine statute was reviewed by the SHIP on September 16, 1981. At that time the state was not in full compliance with the Baucus amendment.

Regulations were proposed by the Superintendent of Insurance and a public hearing was held on May 14, 1982. The regulations are similar to the NAIC model, but include a more restrictive definition of the term "skilled nursing facility." It is anticipated that the state will be in full compliance by July 1, 1982.

Maryland *

Section 468 B of the Maryland Insurance Code defines the terms Medicare, Medicare benefit and Medicare eligible expense. Sections 468 C, D, E, F, G, and H of the Code cover provisions of Medicare supplement policies, require procedures for the sale of policies, prohibitions and minimum loss ratios for specified disease policies. SB 185 also regulates Medicare supplement policies, stating that the requirements of Sections 468 B through H also apply to individual and certain group health policies and to certificates issued by nonprofit health service plans.

Section 468 D authorizes the Commissioner to establish a minimum loss ratio at 60 percent for individual and 75 percent for group policies. These loss ratios went into effect September 1, 1981.

The SHIP reviewed Maryland's regulatory program on September 16, 1981, finding several deficiencies. Under the minimum benefits provision of Section 468 D an additional 365 days on Part A side and Part B minimum can be offered as an option. A written receipt is not required for the Buyer's Guide. The terms hospital, accident, physician, nurse, skilled nursing facility, and sickness are not defined. No six-month preexisting condition limitation, free look provision, outline of coverage or replacement requirements are included. The program was conditionally approved.

Massachusetts *

The sale and content of Medicare supplement insurance in Massachusetts is regulated by Section 110 of Chapter 175 of the Massachusetts Insurance Laws and 211 CMR 47.00, "Rules and Regulations Governing Individual Accident and Sickness Insurance." The regulation contains standards for policy definitions and general rules on required disclosures and policy and rate filings and reviews.

211 CMR 47.00 establishes minimum standards for specified disease coverage and Medicare supplement coverage. Each specified disease policy must have a maximum benefit of no less than $10,000 and must provide benefits for at least twelve specific conditions. Specified disease coverage must be renewable until age 65 and may not be sold to anyone over age 65.

Medicare supplement insurance may not be sold to anyone not covered by Medicare Parts A and B. Three categories of Medicare supplement policies are established. Each is mandatory "as to standards and benefits and may not be modified." The three plans are very similar in most basic inpatient and outpatient services. However, the two lower options have less coverage for certain services; for instance, inpatient private nurses and prescription drugs used outside a hospital.

The Massachusetts regulatory program was reviewed June 26, 1981, and found deficient in the following areas:

- no authority to regulate groups;
- no requirements for 75 percent loss ratio on group policies
- the 61st through 90th day coverage requirement does not provide reimbursement for blood;
- it does not require Part A coverage for an additional 365 days of coverage after the lifetime reserve;
- it does not require a policy to supplement all Part B covered services;
- no Buyer's Guide requirement; and
- the outline of coverage omits certain items and differs in format from the NAIC model.

At the December 17, 1981, SHIP meeting, Massachusetts was listed as one of the six states which was not expected to be in compliance by July 1, 1982.

Michigan *

The Michigan legislature has passed several laws relating to the sale and content of Medicare supplement policies. PA 329 of 1980 requires the delivery of a buyer's guide at the time of application, and describes an outline of coverage form for Medicare supplement policies. SB 371 is the proposed law that applies to commercial insurers. It defines the terms which are explained in the NAIC model regulation, describes an outline of coverage and would set loss ratios at 75 percent for group and 60 percent for individual policies. Since SB 371 has not become law, the only loss ratio standard is found in Rule 500.801, which sets the group ratio at 75 percent.

PA 350 of 1980 regulates Blue Cross and Blue Shield of Michigan. Sections 607, 608, 609 and 610 authorize the Commissioner of Insurance to approve, disapprove or modify rates of the BC/BS plans. Section 412 of PA 350 requires the delivery of a buyer's guide, and Section 413 requires that an outline of coverage be provided to an applicant.

The SHIP reviewed Michigan's program October 19, 1981 and issued an advisory opinion. The Michigan laws were reviewed again on December 17, 1981. Several problems were discussed at these meetings. At the December meeting it was revealed that the state would like to reach a binding voluntary agreement with Blue Cross and Blue Shield of Michigan. The deficiencies noted at the December meeting were:

- Does not require coverage of 90 percent of Part A expenses up to 365 additional days.
- No free-look provision.
- No requirement for written acknowledgement of receipt of buyer's guide.
- No replacement requirements.
- Prohibition of "Medigap."

The Michigan program was granted an advisory opinion at the December meeting.

Minnesota *

Chapter 318 of the Laws of 1981 contains Minnesota's enabling legislation for sale and content of Medicare supplement policies. The law sets minimum benefit and disclosure standards. Loss ratios are 65 percent for individual and 75 percent for group policies.

Chapter 318 describes four levels of Medicare supplement coverage. They are Medicare Supplement 1+, 1, 2, and 3. 1+ coverage is the most comprehensive and 3 is the least. A Medicare Supplement 1+ policy includes a $1,000 limitation per person on out-of-pocket expenses. Policies with 2 and 3 level coverage do not include Part A Medicare eligible expenses for hospitalization for the first 60 days of a benefit period.

The Insurance Division of the Department of Commerce has proposed rules relating to Chapter 318 which contain prototypes of the four types of Medicare supplement policies.

Minnesota's regulatory program was conditionally approved by the SHIP on September 16, 1981, although at that time the state was under a restraining order while the constitutionality of its program was being reviewed by the state courts. The injunction was lifted in January 1982.

During the initial review, the SHIP noted the following program deficiencies:

- failure to require delivery of a Buyer's Guide;
- does not comply with the outline of coverage requirement; and
- does not comply with replacement requirements.

Bulletin 82-2, issued March 9, 1982, corrected these inadequacies.

Mississippi

Mississippi enacted HB 955, the enabling legislation for Medicare supplement policies, effective October 1, 1981. The Commission is authorized to establish minimum benefit standards and loss ratios for such policies.

Reg. 82-101, "Minimum Standards for Medicare Supplement Policies," includes provisions for the standardization of coverage and simplification of terms and benefits of these contracts, and requires full disclosure for policies sold to persons eligible for Medicare by reason of age. The loss ratio is set at 75 percent for group and 60 percent for individual policies. Use of the NAIC/HCFA Buyer's Guide is required. In addition, in the case of direct response insurers a copy of a form acknowledging receipt of the Buyer's Guide signed by the insured shall be returned to the insurer. The effective date of these regulations is June 30, 1982. The SHIP approved the law and regulations on December 17, 1981.

Missouri *

Missouri Regulation 4 CSR 190-14.110, effective April 1, 1981, entitled "Loss Ratio Under Medicare Supplement Policies," prescribes a minimum loss ratio of 75 percent for group and 60 percent for individual policies. A minimum standard of coverage is also provided.

SB 347, the Missouri Medicare Supplement Insurance Act, contains definitions equivalent to those in the NAIC model, as well as minimum benefit, loss ratio, disclosure standards and replacement requirements. The law shall become effective July 1, 1982.

The SHIP reviewed Missouri's program on December 17, 1981, and found the following deficiencies: no authority over groups or nonprofit insurers regarding delivery of the Buyer's Guide, outline of coverage, replacement requirements, and no prohibition of the use of the terms "Medicare Supplement" and Medigap." The Missouri program was conditionally approved pending correction of these deficiencies. SB 815, effective May 25, 1982, corrected these deficiencies.

Montana

The Montana Medicare Supplement Insurance Standards Act, which became effective April 8, 1981, authorizes the Commissioner to set minimum loss ratio standards.

The Commissioner of Insurance repealed Rule 6.6.501, which required disclosure statements in Medicare supplement policies, in late 1981. A new set of rules, effective February 1, 1982, regulate minimum benefit standards and disclosure provisions. Loss ratios were established by Rule VII at 75 percent for group policies and 60 percent for individual.

The law and regulations, similar to the provisions of the Baucus Amendment, were approved by the SHIP on December 17, 1981.

Nebraska

Nebraska's enabling Medicare supplement legislation is LB 877, effective December 31, 1981. The legislation:

- defines benefit period, Medicare, and Medicare eligible expenses;
- empowers the Department of Insurance to establish standards of disclosure, preexisting conditions, definitions of terms, and minimum benefits;
- requires the Department to establish an outline of coverage; and
- limits the preexisting condition period to six months.

Rule No. 36, effective December 30, 1980, regulates Medicare supplement policies in the state. Although it has been amended it applies only to individual policies. Among its provisions are:

- establishment of loss ratios of 60 percent for optionally renewable, 55 percent for conditionally and guaranteed renewable, and 50 percent for noncancellable policies;
- establishes minimum benefits as in the NAIC model plus coinsurance coverage in SNF for days 21-100;
- provides a 30-day free-look period;
- includes a special disclosure provision that certification and reporting of loss ratios is required; and
- requires special outlines of coverage for hospital indemnity, specified disease and nursing home coverage to be delivered at the time of application.

The provisions of Rule 36 generally conform to the NAIC model, except that the original version was limited to individual policies and did not prohibit use of such terms as "Medicare supplement" and "Medigap" in policies not meeting minimum standards.

LB 329, effective December 31, 1981, extends the applicability of the Medigap legislation and regulations to group policies and certification thereunder.

Rule 36, effective December 31, 1981, was expanded to include group policies and to prohibit the terms "Medicare supplement" and "Medigap" in policies that do not meet minimum standards.

The SHIP approved Nebraska's program on October 19, 1981.

Nevada *

Nevada's Division of Insurance and Department of Commerce promulgated Regulation LH-9 on minimum standards for Medicare supplements. The regulation contains definitions equivalent to those in the NAIC model for hospital, Medicare, benefit period, accident, physician, nurse, skilled nursing facility, sickness, and Medicare eligible expense. It also describes minimum benefit and disclosure standards, and prohibited policy provisions.

Nevada's program was reviewed on December 17, 1981, and the following deficiencies were noted: no specific loss ratio requirements for group and individual policies; no provision for delivery of a Buyer's Guide; no prohibition on the use of such terms as "Medicare supplement" and "Medigap" if the policy does not meet the minimum standards.

Nevada has agreed to amend LH-9 to include loss ratio standards and the provision for delivery of a Buyer's Guide. An official of Nevada's Department of Insurance present at the SHIP meeting stated that she believed that existing language in LH-9 was sufficient to prohibit the use of the terms "Medigap" and "Medicare supplement." Nevada's program was conditionally approved pending correction of the first two deficiencies.

New Hampshire

RSA 4.15A of the New Hampshire Insurance Code authorizes the Insurance Commissioner to establish minimum standards. Regulation 26 specifies minimum benefit standards and disclosure requirements for Medicare supplement policies, and sets loss ratios at 60 percent for individual and 75 percent for group policies. SB 89, which became effective August 22, 1981, establishes a six-month maximum for preexisting conditions.

The SHIP reviewed the state's regulatory program on June 26, 1981, and approved it.

New Jersey *

New Jersey passed AB 1474 authorizing the Commissioner of Insurance to establish minimum standards for full and fair disclosure for the form, content and sale of Medicare supplement individual health insurance policies, in 1979.

Subchapter 16 describes prohibited policy provisions, required disclosure provisions and minimum benefit standards. Definitions of the terms accident, sickness, hospital, skilled nursing facility, physician, nurse, Medicare, Medicare eligible person, and Medicare eligible expense are included.

The purpose of Subchapter 17, the Health Insurance Solicitation Regulation, is to eliminate unfair and deceptive practices in the promotion, solicitation and sale of individual health insurance. It also contains replacement requirements.

Subchapter 18, "Individual Health Insurance Rate Filings," sets loss ratios: for over 65 coverage the ratio is at least 60 percent.

New Jersey's Department of Insurance has written its own buyer's guide, entitled "Adding to Medicare."

The SHIP reviewed New Jersey's program on December 17, 1981, and found the following deficiencies: the regulations apply only to group policies and not to subscriber contracts; there is no requirement for a written receipt for the Buyer's Guide; the outline of coverage does not refer to services not covered by Medicare. It appears that New Jersey will not be in compliance by July 1, 1982.

New Mexico *

New Mexico began to regulate Medicare supplement policies in 1977 with implementation of Rule 4 of the Regulations of the Department of Insurance. Rule 4 deals with disclosure requirements governing the sale of individual Medicare supplement policies.

Chapter 355 (SB 314) of the New Mexico Insurance Code was enacted in 1981. SB 314, effective June 19, 1981, is the basic enabling legislation for the sale and content of Medicare supplement policies. It authorizes the Superintendent of Insurance to establish minimum standards for benefits, loss ratios and disclosure.

The Department of Insurance's proposed regulations are basically the same as in the NAIC model. Loss ratios are 75 percent for group and 60 percent for individual policies.

New Mexico's regulatory program was reviewed by the SHIP December 17, 1981, and conditionally approved pending finalization of the proposed regulation.

New York *

Section 174 of the New York Insurance Law is the basic statute relating to minimum standards of form, content and sale of health insurance. It became effective in 1971 and was later amended. Although it has no specific Medicare supplement provisions, it applies to Medicare supplement policies as well as to other types of health insurance.

The statute enables the Superintendent to issue regulations to establish minimum standards, including disclosure. The purposes of these standards are generally described as:

- reasonable standardization and simplification of coverage;
- elimination of misleading or confusing provisions;
- elimination of deceptive sales practices;
- elimination of provisions which may be contrary to the health care needs of the public; and
- elimination of coverage which is so limited in scope as to be of no substantial economic value to the insured.

The amendments to the law stipulate that the Superintendent establish standard claim forms for the services of all hospitals, physicians and other health care providers, and that all insurers within the state be required to use them by January 1, 1979.

AB 7050-C specifically relates to Medicare supplement insurance. It requires that the Superintendent promulgate rules on or before January 1, 1981, which:

- establish minimum standards of coverage;
- establish an appropriate loss ratio;
- provide for full disclosure with clear language;
- prohibit use of the terms 'supplemental to Medicare'' unless the policy conforms to minimum standards;
- provide for publication and dissemination of a buyer's guide;
- require that every insurer issuing Medicare supplement policies file a report of claims experience every 12 months; and
- provide a definition of Medicare supplement insurance.

The basic regulations applying to Medicare supplement insurance in New York are the eight amendments to Regulation No. 62, which deal with Medicare minimum standards, and the Second Amendment to Regulation No. 34, which relates to advertisement of accident and health insurance.

The rules contain a definition of Medicare supplement policy which does not include group policies. However, disclosure rules are applicable to certificates under in-state group policies and loss ratio requirements are given for group policies.

Required loss ratios are 60 percent for individual and 75 percent for group policies. However, there is no minimum loss ratio for Medicare supplement policies purchased by individuals under age 65. There is a requirement that the anticipated loss ratio be printed on the policy.

The rule limits preexisting condition waiting periods to six months. Two levels of minimum benefits are established:

- *Option I*—conforms to the NAIC model; and
- *Option II*—covers the Part A deductible plus model benefits, except for coverage of 20 percent of eligible Part B expenses when hospital confined. Model requires coverage regardless of hospital confinement.

An outline of coverage must be provided at the time of application for a policy, but no written receipt is required. A buyer's guide must be provided only upon request.

Regulation 62 (Eighth Amendment) also contains standards for annual reporting of experience data for all policies sold to those 65 and over (as required in AB 7050-C).

On September 18, 1981, the New York Insurance Department sent a letter to the SHIP indicating New York's unwillingness to submit its program for regulatory review. Nevertheless, a review was conducted, which noted the following deficiencies:

- lack of group authority;
- Option II's failure to require a policy to supplement Part B benefits when the patient is not confined to a hospital;
- lack of a requirement for delivery of a buyer's guide unless requested; and
- failure to require a written receipt for outline of coverage.

The SHIP issued an advisory opinion outlining necessary changes and indicated that the Voluntary Certification Program will apply beginning in July 1982 unless the changes are made.

North Carolina

North Carolina has enacted several laws pertaining to the sale and content of Medicare supplement policies. SB 449 is the basic enabling legislation, which also specifies loss ratios and disclosure requirements. It took effect January 1, 1982.

The North Carolina Department of Insurance publishes its own buyer's guide, "Important Insurance Information for People Who Get Medicare." All prospective purchasers of insurance shall be provided with the NAIC/HCFA Guide to Health Insurance for People with Medicare, as well as the state's buyer's guide. Rules on these buyer's guides are in Regulations NCAC 12.0208 and 12.0548.

SHIP conditionally approved North Carolina's program on September 16, 1981, but there was a need to change the definition of the term "Medicare supplement policy" in SB 449. HB 1392, ratified October 10, 1981, accomplished this, and final approval was granted November 23, 1981.

North Dakota

HB 1438, North Dakota's basic enabling legislation, became effective July 1, 1981. It provides minimum standards for Medicare supplement policies and establishes the responsibilities of the Commissioner of Insurance. The legislation provides for an outline of coverage for Medicare supplement policies to be delivered to applicants, includes disclosure standards, and sets a loss ratio of 60 percent for individual policies.

Chapter 45-08-01 of the North Dakota Century Code explains Medicare supplement insurance minimum standards. The regulations set loss ratios at 75 percent for group and 60 percent for individual policies, and include disclosure provisions which require the use of a buyer's guide.

When SHIP reviewed North Dakota's program there was a problem in that "foot care" was not included in the regulations as an exclusion which cannot be more restrictive than Medicare. SHIP's initial recommendation of conditional approval was changed to approved on November 23, 1981, when "foot care" was added to the list of exclusions.

Ohio *

Ohio's Rule 3901-3S, "Solicitation and Sale of Medicare Supplement Accident and Health Policies," became effective January 1, 1979. It defines "unfair or deceptive acts" but does not apply to group, blanket or franchise accident and health insurance.

HB 579 authorizes the Superintendent of Insurance to adopt rules on the sale and content of Medicare supplement policies that: establish specific standards for policy provisions; establish loss ratios; prescribe a standard form and contents of an information brochure; and provide for fair disclosure. He also is authorized to promulgate rules that are necessary to meet the requirements of PL 96-265.

In response, the Superintendent proposed Regulation 3901-1-41, which basically follows the NAIC model. A public hearing was held April 27, 1982.

The Ohio Department of Insurance uses two buyers guides; the NAIC/HCFA booklet, and one developed by the Department entitled, "What Older Ohioans Should Know About Health and Accident Insurance." The latter includes information on government health insurance plans, cancer plans, skilled nursing home plans, hospitalization plans, types of individual contracts, and dealing with agents.

Ohio's program was conditionally approved by the SHIP September 16, 1981, subject to adoption of the law and regulation. The law was enacted March 15, 1982, and became effective that day.

Oklahoma *

Oklahoma's enabling legislation (HB 1410) authorizes the Commissioner to issue regulations to set standards for Medicare supplement policies, including loss ratios and disclosures. Rules for minimum standards and benefits (Rule 73) were proposed by the Department of Insurance. A public hearing was held on August 5, 1981. These regulations follow the NAIC model. Loss ratios are 75 percent for group and 60 percent for individual policies. Rule 73, which also requires use of the NAIC/HCFA Buyer's Guide, will become effective July 1, 1982.

Oklahoma has also adopted Rule 12-2, pertaining to advertising of accident and health, hospitalization and disability insurance, effective November 1, 1973.

The SHIP conditionally approved Oklahoma's legislation, pending finalization of the proposed regulations, November 23, 1981.

Oregon

The basic enabling legislation on Medicare supplement insurance is SB 855, effective July, 1979. It authorizes the Commissioner to set minimum benefit standards and to require that the loss ratio be not less than 60 percent. It permits the Commissioner to require insurers to report periodically to demonstrate compliance with the rules.

The basic regulations covering Medicare supplement policies are Oregon Administrative Rules 836-52-106 to 836-52-135, adopted October 22, 1980.

The rules set loss ratios at 60 percent for individual and 75 percent for group policies and establish disclosure requirements. Applicability of the rule is limited to individual and to state group policies and the certificates thereunder. The rules generally conform with the NAIC model with the following exceptions:

- Does not prohibit a waiting period for accidents;
- Replacement requirement does not apply to group policies;
- Does not prohibit use of terms such as "Medigap" and "Medicare Supplement" if the policy fails to meet minimum standards; and
- Needs clarification that Part A and Part B only policies could not be sold as Medicare supplements.

Pending correction of these defects, SHIP conditionally approved Oregon's program September 16, 1981. The Insurance Division revised the rules covering the first three conditions and explained the Part A or Part B only issue to the satisfaction of the SHIP, which approved Oregon's program December 17, 1981.

Pennsylvania *

Pennsylvania's "Individual Accident and Sickness Insurance Minimum Standards Act" (PL 123, No. 54), became effective May 18, 1976. It established standards for policy provisions and minimum benefit standards. It authorized the Commissioner to establish disclosure standards and regulate the format and contents of the outline of coverage.

Chapter 88 of the Department's Rules and Regulations was issued as a result of PL 123, No. 54. It defines the terms hospital, skilled nursing facility, accident,

sickness, physician, nurses, and Medicare, and minimum benefits. Section 88: 169 sets minimum standards for specified disease coverage and Section 88: 170 sets minimum standards for Medicare supplements. Chapter 88, which became effective June 24, 1978, also covers replacement requirements.

Amendments to Chapter 88 define Medicare benefit period and Medicare eligible expense, and establish a preexisting condition limitation. Loss ratios are set at 60 percent for individual policies, and minimum disclosure standards are established.

The SHIP first reviewed Pennsylvania's program March 17, 1981, noting several deficiencies. There was no authority over group policies and no loss ratio for group policies. The program was reviewed again November 23, 1981, and conditionally approved pending finalization of a regulation which contains specific group authority, or submission of a legal opinion from the State Attorney General that groups as contemplated by PL 96-265 are not permitted in Pennsylvania. At the November 23 meeting a Pennsylvania Insurance Department official stated that the state could adopt conforming language regarding groups, but that it could not be effective until September 1982.

Rhode Island *

Title 42, Chapter 62, Section 12 of the Laws of Rhode Island provides specific authority for health insurance minimum standards. Regulation XXIII establishes minimum standards for health benefit plans.

Part VII of Regulation XXIII concerns individual health benefit contracts. It defines the terms: one period of confinement, hospital, skilled nursing facility, accident, sickness, preexisting condition, physician, nurse, Medicare, and mental or nervous disorder, as applied to individual policies. The regulation, which also establishes minimum benefit standards and disclosure requirements, took effect October 9, 1978. An internal memorandum of the Department of Insurance dated November 17, 1979, sets loss ratio standards for Medicare supplement policies at 60 percent.

The SHIP reviewed Rhode Island's program on November 23, 1981, and found many deficiencies. At the December 17, 1981, meeting the state was identified as one of the six that would not be in compliance by July 1, 1982.

Rhode Island's program failed to comply with the federal statute in the following areas:

- six months or less preexisting condition limitation;
- excludes group policies;
- no loss ratio for group policies;
- no definition for benefit period and Medicare eligible expense;
- does not address automatic changes in Medicare cost-sharing amounts
- does not address coverage of Part A hospital coinsurance from 61st to 90th day or during lifetime reserve days;
- does not address coverage of 90 percent of Part A expenses after exhaustion of lifetime reserve to a minimum of 365 additional days;
- does not address coverage of 20 percent of eligible expenses under Part B regardless of hospitalization subject to $200 deductible and maximum of $5,000 per calendar year;
- free-look provision does not meet the 30-day requirement for direct response;
- no requirement for delivery of Buyer's Guide;

- no outline of coverage for Medicare supplement policies;
- replacement requirements apply to individual policies only; and
- does not prohibit use of such terms as "Medicare supplement" and "Medigap" in policies that do not meet minimum standards.

S 2538, the Rhode Island Medicare Supplement Reform Act, enacted by the General Assembly, takes effect July 1, 1982. It defines the term "Medicare supplement policy" and establishes minimum standards. The insurance commissioner is authorized to regulate group policies, disclosure standards, and prohibited policy provisions.

South Carulina *

Chapter 69-34 of the Department of Insurance regulations covers sale and content of Medicare supplement policies. It closely follows the NAIC model, but has several deficiencies. Chapter 69-34 contains definitions of terms relating to Medicare supplements as in the NAIC model, as well as prohibited policy definitions, accident and health minimum standards for benefits and required disclosure provisions. There are provisions for specified disease and accident coverage in the section describing accident and health minimum benefit standards.

Section 38-35-410 of the South Carolina Insurance Laws requires filing accident, health, or accident and health insurance policies with the Commissioner. The Department drew up "Guidelines for Filing of Forms and Rates for Individual Health Insurance," which set loss ratios for individual policies at 60 percent. The guidelines also contain a checklist of items to be included in the "Minimum Requirements as to the Documentation of Individual Health Insurance rate filing submissions."

Two other sections of Chapter 69 regulate Medicare supplement insurance. The purpose of Chapter 69-34.1 is to eliminate unfair and deceptive trade practices in the promotion, solicitation and sale of individual accident and health insurance policies to persons who are qualified for Medicare by reason of age as well as persons currently eligible for Medicaid. Chapter 69-34.2 has as its purpose the elimination of unfair and deceptive practices in the replacement of individual accident and health insurance policies for persons with the same qualifications as in Chapter 69.34.1. The effective date for Chapter 69-34.1 and 69-34.2 is May 14, 1980.

The SHIP conditionally approved South Carolina's program November 23, 1981, noting two deficiencies. There was no indication that there was current authority over groups, and there was no free-look provision for direct response policies.

S 777, which became effective April 13, 1982, stipulates that group Medicare supplement insurance shall meet federal minimum standards and establishes a 75 percent loss ratio. H 2262 establishes a free-look provision for direct response policies.

South Dakota *

South Dakota's Medicare supplement enabling legislation, HB 1280, was enacted on February 18, 1982. The law authorizes the Commissioner of Insurance to promulgate regulations for health insurance policies that supplement Medicare coverage.

Chapter 20:06:13 of the Administrative Rules of South Dakota, effective October 1, 1979, establishes the requirement that a Medicare supplement disclosure form must be furnished to anyone who applies for a policy after that date. Chapter 20:06:10, effective August 9, 1977, regulates the form and content of health insurance advertisements, including benefits payable, losses covered or premiums payable, preexisting conditions and the use of statistics.

South Dakota's regulatory program was reviewed by the SHIP on November 23, 1981. At that time an advisory opinion was sent to the state.

Tennessee

The Commissioner of Insurance was authorized to regulate Medicare supplement policies with the passage of SB 217. The regulations basically follow the NAIC model. Loss ratios are 60 percent for individual and 75 percent for group policies. This regulation provides for a waiver of the loss ratio standard for small premium policies, but the waiver will not be granted for Medicare supplement policies.

Other Department regulations (Chapter 0780-1-20) which took effect on January 1, 1981, relate to the filing of accident and sickness policies. These regulations established loss ratio standards and developed a checklist of minimum requirements to document individual health insurance rate filing submissions.

The SHIP approved Tennessee's law and regulations on October 19, 1981.

Texas

Texas has enacted enabling legislation (SB 726) and promulgated regulations on the sale and content of Medicare supplement policies. SB 726 provides minimum standards for Medicare supplement policies, standards for contractual provisions, and disclosure provisions. The State Board of Insurance was authorized to set minimum loss ratios.

The Board also issued "Truth in Advertising" rules which cover deceptive solicitations for Medigap policies. The rules were revised and adopted on July 29, 1980, and became effective on February 7, 1981.

The rules for minimum standards for Medicare supplement policies (.059.03.74) apply to individual and group policies, and basically follow the NAIC model. Loss ratios are 75 percent for group and 60 percent for individual policies. Disclosure provisions require the use of the NAIC/HCFA Buyer's Guide. The SHIP approved Texas's law and regulations on November 23, 1981.

The Insurance Board published a report, "Insurance Problems of Elderly and Handicapped Texans," in May 1981. It examines all types of insurance, including health insurance and Medicare.

Utah

HB 187, the basic enabling legislation in Utah, was passed in 1979 and enacts Sections 31-44-1 through 31-44-8 of the Utah Code. It applies to all individual accident and health policies, including Medicare supplements. The Commissioner of Insurance is directed to adopt rules and regulations that establish minimum benefits for several types of insurance, including Medicare supplements, and to set disclosure requirements which shall provide a standard form for the content of an informational brochure.

Regulation 80-12 was developed as a result of HB 187. These regulations implement Sections 31-44-1 through 31-44-8 and provide for reasonable standardization and simplification of the terms and coverage of individual accident and sickness policies, health maintenance organization contracts, individual subscriber contracts of hospital, medical and dental service corporations, and Medicare supplement policies. These regulations include extensive rules for specified disease and specific accident coverage, and disclosure provisions.

The Medicare Supplement Insurance Act of 1981, HB 176, amends Sections 31-44-1, 31-44-2, 31-44-4, 31-44-6 and 31-44-8 of the Utah Code. The terms "Medicare supplement policy" and "certificate" are defined. The Commissioner is authorized to adopt rules and regulations regarding minimum benefit standards and specific standards for disclosure. Medicare supplement policies are specifically included, along with individual accident and sickness policies. Use of the NAIC/HCFA Buyer's Guide is required. Loss ratios are set at 75 percent for group and 60 percent for individual policies.

The SHIP approved Utah's program on November 23, 1981.

Vermont

Regulation 80-1, Accident and Minimum Standards, and its amendments govern the sale and content of Medicare supplement policies in Vermont. Regulation 80-1, patterned after the NAIC model, includes prohibited policy provisions, required disclosure provisions and minimum benefit standards.

The Vermont regulation was reviewed by the SHIP and found deficient in three areas. The regulation was amended twice.

The first amendment, effective July 1, 1981, established the loss ratio at 75 percent for group and 60 percent for individual policies. There were several additions to the required disclosure provisions section, including a requirement for disclosure on cancer policies.

The second amendment, effective January 1, 1982, revises the outline of coverage and prohibits use of the term "Medicare supplement" unless the policy meets minimum standards. The original version of Regulation 80-1 allowed a maximum benefit option of $50,000 or 90 percent of Part A expenses after exhaustion of a lifetime reserve to a lifetime maximum benefit of 365 additional days. This amendment deleted the phrase, "$50,000 or."

Vermont also enacted HB 214, which extends the Medicare supplement free-look period from 10 to 30 days. The law was signed on April 14, 1981.

On November 23, 1981, the SHIP reviewed Vermont's law and regulations again, upgrading its conditional status to approved.

Virginia

The legislative base for the regulation of the sale and content of Medicare supplement policies in Virginia is a number of statutes. S 38.1-348.4 of the Code of Virginia, dating from 1966, allows a 10-day free-look period for any purchase of accident and sickness insurance.

SB 767 (Chapter 575, Laws of 1981), which will take effect on July 1, 1982, amends and reenacts sections 38.1-362.13, 38.1-362.15, and 38.1-818, and adds new sections 38.1-362.8:1, 38.1-36.8:2, 38.1-362.8:3, 38.1-818.1, and 38.1-362.17. Some sections apply to accident and sickness policies in general (including Medigap), others relate specifically to Medigap. Provisions of this statute:

- empower the State Corporation Commission to issue rules and regulations to establish standards relating to disclosure, coverage, preexisting conditions and other areas;
- extend the free-look period to 30 days for policies issued pursuant to a direct response solicitation; and
- limit preexisting conditions waiting period to 6 months.

Article 2.3 of the Code of Virginia, the Individual Accident and Sickness Insurance Minimum standards Act, became effective in 1980. The act requires:

- that an outline of coverage be provided at the time the application is made or the policy delivered (format to be prescribed by the Commissioner); and
- reasonable standardization, simplification of terms and full disclosure.

The regulations allow for three categories of Medigap coverage:

- Medicare Supplement 1—Model NAIC benefits;
- Medicare Supplement 2—Model benefits plus Part A deductible plus 21-100 day SNF coverage plus deductible of $100 a year and maximum yearly benefit of $10,000 under part B; and
- Medicare Supplement 3—As in 2, plus 80 percent of drugs, three pints of blood and no Part B limit.

Policies must be labeled as to which minimum benefit category they fall under.

The major Medicare supplement regulation is No. 20, which became effective on February 1, 1981, but was amended. The amended version becomes effective on July 1, 1982. Provisions of Amended Regulation 20:

- extend applicability from individual policies only to individual and in-state group policies and the certificates thereunder;
- limit the preexisting condition waiting period to 6 months in all circumstances (the previous version had allowed a period of 12 months for simplified applications with no health questions); and
- provide for delivery of the Buyer's Guide with all policies and certificates to those 65 or over (instead of only with Medicare supplements as previously required).

Insurance Regulation No. 18 (effective January 1, 1981) contains specific provisions related to readability for all accident and sickness policies, including Medigap. It provides that all policy forms must achieve a minimum Flesch reading ease score of 40 or an equivalent score on a comparable test as approved by the Commission.

Insurance Regulation No. 22 (effective October 1, 1981) includes rules governing the filing of rates for accident and sickness policy forms, including Medigap. It also specifies loss ratios of 60 percent for individual and 75 percent for group policies.

The SHIP conditionally approved Virginia's program on September 16, 1981, because of deficiencies related to blood coverage. The Panel noted that:

- Supplements 1 and 2 did not cover blood deductibles during days 61-90; and
- Supplements 1 and 2 did not include blood deductible in $200 out-of-pocket expenses.

The State Corporation Commission acted on November 25, 1981, to delete the references to blood from Regulation 20 in order to bring its regulations into compliance with NAIC standards.

The SHIP approved Virginia's program on December 17, 1981.

Washington *

Washington enacted its Medicare Supplement Disclosure Requirements, WAC 284-50-45 through 65, in August 1978. The purpose of the regulations is to "establish specific standards for full and fair disclosure in the sale of health and accident insurance that is supplemental to federal Medicare insurance."

Order Adopting Rules (No. R 76-4) relating to individual disability insurance minimum standards and disclosure requirements was adopted on October 19, 1976. These rules, WAC 284-50-300 through 284-50-435, provide reasonable standardization and simplification of terms and coverage of individual disability insurance policies. The policy definitions include the terms: hospital, skilled nursing facility, accident, sickness, and nurse.

Substitute HB 297, "Medicare Supplemental Health Insurance Act," is intended to govern the contract and sale of Medicare supplement insurance. The law defines the terms Medicare, Medicare eligible expense and Medicare benefit period. The Commissioner is authorized to issue regulations for prohibited policy provisions. HB 297 sets loss ratios at 75 percent for group and 60 percent for individual policies. The law became effective on January 1, 1982.

The SHIP conditionally approved Washington's program on September 16, 1981, noting the following deficiencies:

- no provision requiring delivery of a Buyer's Guide;
- outline of coverage requirement does not follow the NAIC model format; and
- no prohibition of the use of the terms "Medicare supplement" or "Medigap" for policies which do not meet the minimum standards.

When the program was re-reviewed on December 17, 1981, it was found that the state was willing to change the deficiencies which were found in September. However, there was an indication that the state intended to include additional language authorizing the Commissioner to permit insurers to indemnify accidents at a different rate than sickness. The program was conditionally approved pending elimination of the language and making the changes noted above.

West Virginia

Individual Accident and Sickness Insurance Minimum Standards became part of West Virginia's Administrative Regulations in February 1975. These minimum standards include policy definitions for hospital, accident, physician, skilled nursing facility, and sickness. The regulation also included minimum standards for benefits, required disclosure provisions and requirements for replacement for accident and sickness insurance. Under the minimum benefit standards section are specified disease and specified accident coverage provisions.

Section 33-16-3d of the Code relates to Medicare supplement insurance. It authorizes the Commissioner to issue reasonable regulations to establish specific standards for policy provisions, minimum benefits, loss ratios and disclosure.

The Commissioner promulgated regulations (Administrative Regulation 33-2) relating to Medicare supplement policies which became effective on December 28, 1981. Definitions of the terms applicant, certificate, duplication of insurance, limited benefit supplement policy, replacement of insurance, and sales materials are included. The regulations follow the NAIC model, but are stronger in certain areas. Minimum standards for both Medicare Supplement and Limited Benefit Medicare Supplement policies and contracts are established. A "Limited

Benefit Medicare Supplement Policy'' contains provisions that are as strict as the NAIC Minimum Standards Regulation. The term ''Medicare Supplement'' refers to policies with more comprehensive coverage.

The SHIP approved West Virginia's regulatory program on October 19, 1981.

Wisconsin *

Section Ins. 3.39 of the Wisconsin Administrative Code establishes minimum standards and disclosure requirements for Medicare supplements. The rule, which became effective in January 1978, calls for the establishment of five clearly defined categories of Medicare supplement insurance.

Changes to Ins. 3.39 have been proposed. One, in May 1981, decreased the number of policy categories to three. July 1, 1982, revisions, which meet or exceed the NAIC model, set the following loss ratio standards:

- at least 60 percent in the case of individual policies;
- at least 60 percent in the case of group policies issued as a result of solicitations of individuals through the mail or mass media advertising; and
- at least 75 percent in the case of group policies other than those described above.

The office of the Commissioner of Insurance publishes a Buyer's Guide entitled ''Health Insurance Advice for Senior Citizens.'' The publication describes what Parts A and B of Medicare cover. It also explains the three Medicare supplement categories:

Medicare Supplement 1:

- will pay most of medically necessary health care expenses left unpaid by Medicare;
- will cover medical expenses in excess of Medicare allowable charges;
- will cover most self-administered prescription drug expenses and some outpatient psychiatric treatment.

Medicare Supplement 2:

- offers major broad-based protection;
- benefits for medical expenses are usually limited to what is considered allowable charges.

Medicare Supplement 3:

- selective but substantial coverage;
- do not have to cover skilled nursing care, psychiatric care or prescription drugs.

Chapter 82 of the Laws of 1981 (AB 489) authorizes the Commissioner to establish rules for minimum benefits, loss ratios and disclosure standards.

The SHIP conditionally approved Wisconsin's program pending finalization of the proposed regulation on December 17, 1981.

Wyoming *

The Wyoming Medicare Supplement Regulation (Chapter 35), governing the sale and advertising of Medicare supplement insurance, became effective on October 1, 1980.

It sets minimum benefits, prohibited policy provisions, loss ratios and disclosure standards. Section 6 deals with minimum benefits and explains the

three types of Medicare supplement policies allowed by the state. They are: "Medicare Part A Only Policy-Limited Coverage," "Medicare Supplement Part B Policy-Limited Coverage," and "Medicare Supplement Policy Parts A and B."

The SHIP's review of Wyoming's program on September 16, 1981, revealed the following deficiencies:

- inadequate definitions of hospital and skilled nursing facility;
- no definition of Medicare eligible expense;
- no requirement of coverage of both Part A and Part B minimum;
- coverage of eligible expenses from 61st through 90th day does not include blood; and
- reasonable charge is based on insurer's, not Medicare's determination.

The regulation was promulgated again on October 13, 1981. All of the above inadequacies except the coverage of Part A and Part B minimums, and the determination of reasonable charge had been corrected. SHIP reviewed Wyoming's program on November 23, 1981, at which time the state submitted a letter to the Panel stating that it did not plan any additional changes. At the December 17th meeting the state was listed as one of the six that did not plan to comply by the July 1982 deadline.

ADDENDUM

The Supplemental Health Insurance Panel held a meeting on June 9, 1982. The Panel reviewed the regulatory activity in the states that had previously been granted conditional approval.

CONNECTICUT

It is anticipated that amendments to Administrative Regulation 38-174 shall go into effect by January 1983. Connecticut's program was approved.

DELAWARE

HB 547 is awaiting the signature of the Governor. Delaware's program was conditionally approved.

HAWAII

Hawaii's regulation has become final with an effective date of June 30, 1982. The state's program was approved.

IDAHO

Regulation 40 became effective May 1, 1982. Idaho's program was approved.

ILLINOIS

Regulation 20.08 became effective June 1, 1982. Illinois' program was approved.

INDIANA

Regulation 31 will go into effect on July 1, 1982. Indiana's program was approved.

KENTUCKY

Additional amendments were proposed June 1, 1982. It is anticipated that the changes will go into effect June 25, 1982. Kentucky's program was approved.

LOUISIANA

The state's proposed regulation needs to be approved by the Senate and House Commerce Committees. It is anticipated that the regulations will be promulgated in August 1982. The Louisiana program was approved.

MAINE

The regulations will go into effect by July 1, 1982. Maine's program was approved.

MARYLAND

An emergency regulation was promulgated which corrects the existing deficiencies. The regulation shall be in effect for 90 days. Maryland's program was approved.

MICHIGAN

SB 371 is expected to pass into law by July 1, 1982. The state will not be in compliance with the provisions of the Baucus Amendment by the July deadline.

MINNESOTA

Minnesota's program was approved.

MISSOURI

The Missouri regulatory program was approved.

NEVADA

Nevada has amended its regulation to correct the deficiencies noted by the SHIP. The state's program was approved.

NEW MEXICO

The state's regulation has become final and went into effect June 1, 1982. Nevada's program was approved.

OHIO

Ohio Rule 3901-1-41 has become final and has an effective date of July 1, 1982. The state's program was approved.

OKLAHOMA

Rule 73 has become final and will take effect July 1, 1982. Oklahoma's program was approved.

SOUTH CAROLINA

The deficiencies in the state's regulatory program which were noted at the November 1981 SHIP meeting have been corrected by the passage of S 777 and H 2262. South Carolina's program was approved.

SOUTH DAKOTA

The state's program was conditionally approved.

WASHINGTON

The Department of Insurance has issued two amending orders which correct several of the deficiencies noted at the December SHIP meeting. Order No. R 81-6 prohibits the use of the terms "Medicare Supplement" or "Medigap" for policies that do not meet minimum standards. Order No. R 81-7 corrects the outline of coverage deficiency. The lack of a requirement concerning the delivery of a buyer's guide has been corrected by an amendment to the Washington regulations. The state's program was approved.

WISCONSIN

Amendments to Ins. 3.39 have become final and have an effective date of July 1, 1982. Wisconsin's program was approved.

As of December 31, 1981, there were seven states that were not expected to meet the Federal Minimum Standards by July 1, 1982. These states were also reviewed at the June 9, 1982, SHIP meeting.

CALIFORNIA

California is now expected to comply by July 1982. The advisory opinion was changed to conditional approval.

MASSACHUSETTS

The Massachusetts regulatory program was disapproved in its present form.

NEW JERSEY

New Jersey is not expected to meet the Federal Minimum Standards by July 1, 1982.

NEW YORK

New York is not expected to meet the Federal Minimum Standards by July 1, 1982.

PENNSYLVANIA

Legislation has been introduced in the state which addresses the deficiencies relating to group policies. The legislature is out of session until September 1982. The state is not expected to meet the Federal Minimum Standards by July 1, 1982.

RHODE ISLAND

Rhode Island is not expected to meet the Federal Minimum Standards by July 1, 1982.

WYOMING

Wyoming is not expected to meet the Federal Minimum Standards by July 1, 1982.

CHAPTER V

Summary Table of Specific State Laws and Regulations Governing Medigap Policies

Key
G—Group I—Individual A.O.—Advisory Opinion NA—Not Applicable

Summary Table of Specific State Laws and Regulations Governing Medigap Policies

			Description				Reviewed by HCFA		Type of Change Needed			Other Comments
State	Cit. Law-Reg.	Effec. Date	Min. Stds.	Dis-clo-sure	Loss Ratio	Adv.	Cond. App. Date	Full App. Date	Law	Reg	Description	
AL	Act 81-560	1-1-82	enabling legis	X	X			10-19-81				Regulation follows the NAIC model.
	Reg 71	1-1-82	X	X	75% G 60% I							
AK	SB 43	9-23-81	enabling legis				6-26-81	9-16-81				State's regulatory program complies with the Baucus amendment.
	Prop Reg Ch 28	NA	X	X	75% G 60% I							
AZ	Rule R 4-14-606	6-1-81	X	X			9-16-81	11-23-81				State's rule encompasses MS requirements. Originally adopted 5-80. Amended to add several disclosure requirements 1-82.
AR	HB 353, Act 810	3-28-81	enabling legis					6-26-81				Regulation and law include all MS requirements.
	Reg 27	8-1-81	X	X	75% G 60% I							
CA	AB 2947	1-1-81	enabling legis	X			11-23-81 12-17-81 A.O. 6-9-82			X	Dept. of Insurance needs to adopt group loss ratio requirements.	Regulation along with necessary changes expected during fall of 1982.
	AB 1807, Ch 731	1-1-82	enabling legis	X	X							
	Prop Regs CAC Title 10 Ch 5	NA			60%							
	CAC Title 10, Art Sec 12.2	4-15-75 amended 2-76		X								

			Description				Reviewed by HCFA		Type of Change Needed			Other Comments
State	Cit. Law-Reg.	Effec. Date	Min. Stds.	Dis-clo-sure	Loss Ratio	Adv.	Cond. App. Date	Full App. Date	Law	Reg	Description	
CO	HB 1256	6-4-81	X	X	75% G 60% 1			10-19-81				State's regulatory program complies with the requirements of the NAIC model.
	Reg 81-1	1-1-82	X	X	X							
	Reg 78-1	6-11-79			X							
	Reg 78-2	6-11-79		X								
	Reg 76-6	7-1-77			X							
CT	PA 79-289	10-1-79	enabling legis		70% G 65% 1		11-23-81	6-9-82				State's regulatory program complies with the requirements of the NAIC model. Administrative requirements needed.
	AR 38-184	4-7-81		X								
	PA 81-97	10-1-81			75%							
	Prop Amend to Regs 38-174 m(c)13-21	NA	X	X								
DE	Prop HB 547	NA	enabling legis	X			6-9-82		X	X	Awaiting passage of law and subsequent promulgation of regulations.	As of June 9, 1982, the state is expected to be in compliance by July 1, 1982.
FL	Dept Ins Rules Ch 4-51	1-1-81	X	X			6-26-81	9-16-81				State's regulatory program follows the requirements of the NAIC model, but includes out-of-state and in-state group policies.
	Stat 627. 671-675	1-1-81	X	X	75% G 60% 1							
GA	SB 451 Act 1301	11-1-80	enabling legis				6-26-81	9-16-81				State's regulatory program follows NAIC model except for several disclosure requirements and does not allow the sale of MS policies to Medicaid recipients.
	HB 1439 Act 1340	4-1-80		X								
	GA Rules & Regs Ch 120-2-8	11-1-80	X	X	X	X						
HI	SB 1713	6-8-81	enabling legis	X			10-19-81	6-9-82				Regulation follows the NAIC model.
	Reg Title 16 Ch 12	6-30-82	X	X	75% G 60% 1							

State	Cit. Law-Reg.	Effec. Date	Description: Min. Stds.	Description: Dis-clo-sure	Description: Loss Ratio	Description: Adv.	Reviewed by HCFA: Cond. App. Date	Reviewed by HCFA: Full App. Date	Type of Change Needed: Law	Type of Change Needed: Reg	Type of Change Needed: Description	Other Comments
ID	S 1078 Title 41 ID Code Ch 44	7-1-81	enabling legis	X	75% G 60% I		11-23-81	6-9-82				Regulation follows the NAIC model. Also requires use of state's own buyers' guide. SB 1078 will expire one year after the Baucus amendment is repealed or expires.
	Reg 40	5-1-82	X	X	75% G 60% I							
IL	Rule 20.08	7-1-82	X	X	X	X	6-26-81 12-23-81	6-9-82				Regulation of MS policies dates from 1977.
	PA 80-435	10-1-77	X	X								
	HB 3435	7-1-81	X	X	75% G 60% I							
	SB 912	7-1-82		X								
IN	H 1878	9-1-81	enabling legis				12-17-81	6-9-82				Regulation follows the NAIC model.
	HB 1372	3-3-80	enabling legis									
	Reg 31	7-1-82	X	X	75% G 60% I							
IA	Ch 514-D	6-1-80	enabling legis	X			10-19-81	11-23-81				State's regulatory program complies with requirements of the NAIC model.
	Ch 510-36	12-31-81			60% I							
	Ch 510-37	12-31-81	X		75% G							
KS	HB 2164	7-1-81	enabling legis	X				10-19-81				Dept of Insurance indicates that the state's regulatory program is more stringent than NAIC model.
	KAR 40-4-5	5-1-82	X	X	75% G 60% I							
KY	HB 179	3-12-80	enabling legis				11-23-81	6-9-82				Changes needed in disclosure requirements. Administrative requirements needed.
	806 KAR 17:060	5-6-81	X	X	65% I							
	HB 86	2-26-82	X	X								
	Prop Amend to 806 KAR 17:060	NA	X	X	75% G							

			Description				Reviewed by HCFA		Type of Change Needed			Other Comments
State	Cit. Law-Reg.	Effec. Date	Min. Stds.	Dis-clo-sure	Loss Ratio	Adv.	Cond. App. Date	Full App. Date	Law	Reg	Description	
LA	SB 965 Act 146	1-1-82	enabling legis		75% G 60% I		12-17-81	6-9-82				Administrative Requirements needed
	Prop Reg	NA	X	X	60%							
	Rule #3	11-1-73				X						
ME	SB 175	9-18-81		X	X		9-16-81	6-9-82				Program complies with requirements of NAIC model, but has a stricter definition of skilled nursing facility. Administrative requirements needed.
	Prop Reg 27	7-1-82	X	X								
MD	SB 185	7-1-81	X				9-16-81	6-9-82				Emergency regulation will expire by 10-1-82. State must issue permanent regulation by that time.
	MD I.C. § 468C	1-1-81	X									
	MD I.C. § 468D	9-1-81			75% G 60% I							
	Emer Reg	7-1-82										
MA	211 CMR			X			6-26-81				Authority to regulate groups. Lacks several required disclosure provisions.	**State does not expect to comply by 7-1-82.** State regulates specified disease policies. State allows three levels of MS policy coverage.
	Prop H 5197	NA			65%							
MI	PA 329	12-19-80		X			10-19-81 12-17-81 A.O. 6-9-82					State not expected to comply by 7-1-82 deadline.
	Prop SB 371	NA	X	X	75% G 60% I							
	Rule 500.801	9-30-74			65% G							
	PA 350	4-3-81		X								
MN	SB 665 Ch 318	8-1-81	X	X	75% G 60% I		9-16-81	6-9-82			Bulletin 82-2 made the necessary changes concerning disclosure requirements.	Enforcement of rule was delayed pending outcome of injunction, which was lifted 1-82. The state allows four levels of MS policies.
	Prop Rules MCAR 1.9361 1.9368	NA	X									
	Bulletin 82-2	3-9-82		X								

State	Cit. Law-Reg.	Effec. Date	Description: Min. Stds.	Description: Dis-clo-sure	Description: Loss Ratio	Description: Adv.	Reviewed by HCFA: Cond. App. Date	Reviewed by HCFA: Full App. Date	Type of Change Needed: Law	Type of Change Needed: Reg	Type of Change Needed: Description	Other Comments
MS	HB 955	10-1-81	enabling legis				11-23-81	12-17-81				State's regulatory program complies with the requirements of NAIC model.
	Reg 82-101	7-1-82		X	75% G 60% I	X						
MO	Reg 4 CSR 190-14110	4-1-81			75% G 60% I		12-17-81	6-9-82				
	SB 347	7-1-82		X	75% G 60% I							
	SB 815	5-25-82	X									
MT	S 241	4-8-81	X	X			9-16-81	12-17-81				State's regulatory program complies with the provisions of Baucus amendment.
	Rule VI	2-1-82	X									
	Rule VII	2-1-82			75% G 60% I							
	Rule VIII	2-1-82		X								
NE	LB877	12-31-81	enabling legis					10-19-81				Rule 36 was amended to include group policies and prohibits use of terms "MS" and "Medi-gap." LB 329 extends applicability of MS legislation to group policies.
	LB 329	12-31-81	X	X								
	Rule 36	12-31-80	X	X	50 % NC 60% OR 55% CR 55% GR							
	Expanded Rule 36	12-31-81			75% G							
NV	LH 9	8-6-80	X	X			12-17-81	6-9-82			No receipt for buyer's guide required.	
NH	RSA 4.15A	8-23-75	enabling legis					6-26-81				State's regulatory program complies with the provisions of the Baucus amendment.
	Reg 26	1-1-81	X	X	75% G 60% I							
	SB 89	8-22-81		X								

State	Cit. Law-Reg.	Effec. Date	Description: Min. Stds.	Description: Dis-clo-sure	Description: Loss Ratio	Description: Adv.	Reviewed by HCFA: Cond. App. Date	Reviewed by HCFA: Full App. Date	Type of Change Needed: Law	Type of Change Needed: Reg	Type of Change Needed: Description	Other Comments
NJ	AB 1474	2-79	enabling legis							X	Lacks several disclo-sure requirements. Does not apply to group policies.	**State not expected to comply by 7-1-82**
	NJAC 11 Subch 16	8-1-81	X	X								
	NJAC 11, Subch 17	8-1-81		X								
	NJAC 11, Subch 18	8-1-81			X							
NM	Rule 4	11-28-77		X			12-17-81	6-9-82				
	S 314, Ch 355	6-19-81	enabling legis									
	NM Ins. Rule 82-1	6-1-82	X	X	75% G 60% I							
NY	AB 7050-C	1-1-81	enabling legis							X	No authority over group MS policies. Lacks several dis-closure requirements.	**State not expected to comply by 7-1-82**
	Reg 62 8th Amend	6-21-81	X	X	75% G 65% I							
	Reg 34 2nd Amend	12-23-80				X						
	NY Ins Law § 174-a	1971 amended 1977	enabling legis									
NC	SB 449	1-1-82	enabling legis	X	75% G 60% I	X	9-16-81	11-23-81				State's regulatory program is in compliance with the provisions of the Baucus amendment.
	HB 1329	10-10-81		X								
	NCAC 12.0208	10-24-81		X								
	NCAC 12.0548	10-24-81		X								
ND	HB 1438	7-1-81	enabling legis	X	60% I		9-16-81	11-23-81				State's regulatory program complies with the provisions of the Baucus amendment.
	Article 45-08	1-1-82	X	X	75% G 60% I							

			Description				Reviewed by HCFA		Type of Change Needed			Other Comments
State	Cit. Law-Reg.	Effec. Date	Min. Stds.	Dis-clo-sure	Loss Ratio	Adv.	Cond. App. Date	Full App. Date	Law	Reg	Description	
OH	HB597	3-15-82	enabling legis				9-16-81	6-9-82				Regulation follows NAIC model. State Insurance Dept uses NAIC/HCFA buyer's guide and state's own guide.
	Rule 3901-1-41	7-1-82	X	X	75% G 60% I							
	Rule 3901-1-35	1-1-79		X								
	Rule 3901-1-16	10-1-74				X						
OK	HB 1410	1-1-82	enabling legis				11-23-81	6-9-82				Regulations follow NAIC model.
	Rule 73	7-1-82	X	X	75% G 60% 1							
	Rule 12-2	11-1-73				X						
OR	SB 855	7-79			60%I		9-16-81	12-17-81				Correction of the deficiencies noted at the 9-16-81 SHIP meeting brought the state into compliance.
	OAR 836-52-106 to 135	10-22-80 4-1-81	X	X	75% G 60% I							
PA	PL 123, No. 54	5-18-76	enabling legis				11-23-81				Conditional approval is pending legislation covering group policies	**State will not be in compliance by 7-1-82 deadline but expects to comply by 10-1-82**
	Title 31, Ch. 88	6-24-78	X									
	Title 31, Ch 88, Amend	9-30-82	X		75% G							
RI	Title 42, Ch 62	1-1-75	X				11-23-81					**State not expected to comply by 7-1-82 deadline.**
	Reg 23	10-9-78		X								
	S 2538	7-1-82	X									

			Description				Reviewed by HCFA		Type of Change Needed			Other Comments
State	Cit. Law-Reg.	Effec. Date	Min. Stds.	Dis-clo-sure	Loss Ratio	Adv.	Cond. App. Date	Full App. Date	Law	Reg	Description	
SC	Ch 69-34	7-13-81	X	X			11-23-81	6-9-82				
	Ch 69-34.1	11-14-80		X								
	Ch 69-34.2	11-14 80		X								
	S 777, Act 318	4-13-82	X		75% G							
	H 2262, Act 284	2-24-82		X								
SD	HB 1280	2-18-82	enabling legis				11-23-81 A.O. 6-9-82				Problem regarding delivery of buyer's guide	
	Ch 20: 06:13	7-1-82	X	X	75% G 60% I							
	Ch 20: 06:05	10-1-79				X						
TN	SB 217	7-1-81	X	X	75% G 60% I			10-19-81				Regulations basically follow NAIC model.
	Rule 0780-1-45	1-1-82	X	X	X							
	Rule 0780-1-20	1-1-81			X							
TX	Substitute SB 726	1-1-82	X	X				11-23-81				State's regulatory program complies with the provisions of the Baucus amendment.
	Rule 059.03.74	6-1-82	X	X	75% G 60% I							
	Board Order 37550	1-1-78				X						
UT	HB 187	5-8-79	enabling legis	X				11-23-81				State's regulatory program complies with the provisions of the Baucus amendment.
	HB 176	5-12-81	enabling legis		75% G 60% I							
	Reg 80-12	1-1-82	X	X	75% G 60% I							

			Description				Reviewed by HCFA		Type of Change Needed			Other Comments
State	Cit. Law-Reg.	Effec. Date	Min. Stds.	Dis-clo-sure	Loss Ratio	Adv.	Cond. App. Date	Full App. Date	Law	Reg	Description	
VT	Reg 80-1	7-1-80	X	X				11-23-81				State's regulatory program complies with the provisions of the Baucus amendment.
	Amends to Reg 80-1	7-1-81		X	75% G 60% I							
	HB 214 Act 19	7-1-82		X								
	VT Ins Code § 4084	1953				X						
VA	VA Code Art 2.3 38 .1-362.10 through .16	7-1-80	enabling legis				9-16-81	12-17-81				State's regulatory program complies with the provisions of the NAIC model.
	VA Code 38.1-362.17	7-1-81	X									
	Reg #20	2-1-81	X	X	75% G 60% I							
	Reg #18	1-1-81	X									
	Reg #22	10-1-81										
	VA Code 38.1-348.4	7-1-66		X								
WA	WAC 284-50, 450, 455, 460, 465	4-20-78		X			9-16-81 12-17-81	6-9-82				
	Substitute HB 891	1-1-82		X	75% G 60% I							
	Admin Order R-81-6	12-8-81	X									
	Admin Order R-81-7	12-8-81		X								

			Description				Reviewed by HCFA		Type of Change Needed			Other Comments
State	Cit. Law-Reg.	Effec. Date	Min. Stds.	Dis-clo-sure	Loss Ratio	Adv.	Cond. App. Date	Full App. Date	Law	Reg	Description	
WV	Ch 33-28	4-1-75	X					10-19-81				Regulations follow NAIC model. There are two types of MS policies allowed in the state.
	§ 33-16-3d	7-11-81										
	Ch 33-2	12-28-81	X	X	X							
WI	AB 489 Ch 82	11-28-81	enabling legis				12-17-81	6-9-82				The state allows three categories of MS policies. Administrative requirements needed.
	Ins 3.39	1-1-78	X	X								
	Amends to Ins. 3.39	7-1-82	X	X	X							
WY	Ch 35	10-1-80	X	X	75% G 60% I		9-16-81 12-17-81			X	No requirement of Part A and Part B minimum coverage.	**State not expected to comply by 7-1-82.** State allows three types of MS policies.

APPENDIX

THE SUPPLEMENTAL HEALTH INSURANCE PANEL'S REPORT TO THE COMMITTEE ON FINANCE OF THE SENATE, AND TO THE COMMITTEES ON ENERGY AND COMMERCE AND WAYS AND MEANS OF THE HOUSE OF REPRESENTATIVES

The Medigap law (section 1882 of Title XVIII of the Social Security Act) is a Congressional effort to create an incentive for states to upgrade their regulation of Medicare supplement health insurance policies. The Supplemental Health Insurance Panel (Panel) is required by section 1882 (i)(2)(B) of the Social Security Act to report to the Committee on Finance of the Senate, and the Committees on Energy and Commerce and Ways and Means of the House of Representatives no later than January 1, 1982. This report must contain the Panel's findings concerning which states cannot be expected to have established by July 1, 1982, an approved state regulatory program as described in 1882(b)(1).[1]

BACKGROUND

Prior to enactment of this legislation on June 9, 1980, there were no federal standards and few states had enacted laws to regulate insurance policies that supplement Medicare. These Medicare supplement, or "Medigap," policies came in many forms, offering a wide variety of benefit packages. Although many offered adequate protection to the elderly, some offered an inordinately small return in benefits for what was paid in premiums, and others were marketed using information misleading as to the scope and extent of the benefits offered.

The National Association of Insurance Commissioners (NAIC) recognized the need to provide for some safeguards for purchasers of Medigap policies, and promulgated such standards in their June 1979 Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act. Investigations by Congress, the Federal Trade Commission and several states confirmed the existence of significant abuses in connection with the marketing and sale of these policies. In an effort to combat the abuses discovered, Congress added section 1882 to Title XVIII of the Social Security Act. This statute is designed to encourage the states to adopt minimum standards for Medicare supplement or Medigap policies, and is based primarily on the provisions contained in the NAIC's June 1979 model law and regulation. Section 1882, however, expands the model's requirements by extending its jurisdiction to certain group policies and by adding loss ratio requirements for both group and individual policies.

As originally proposed, under section 1882, the Secretary of DHHS would determine whether individual state programs met or exceeded the standards contained in the NAIC's June 1979 Model Regulation. However, recognizing the traditional role of the states in regulating the business of insurance, Congress amended its original proposal to give recognition to the expertise in insurance existing at the state level. In its final form, section 1882 established the Panel, composed of four state insurance commissioners appointed by the President, and

[1] This report represents the independent findings of the Supplemental Health Insurance Panel and not necessarily those of the Department of Health and Human Services.

chaired by the Secretary of DHHS, as the body responsible for determining whether state Medicare supplement insurance regulatory programs meet or exceed the minimum standards set forth by the act. A provision was added requiring the Panel to report to Congress by January 1, 1982, the states it believes will not have a program which meets or exceeds the minimum standards in place by July 1, 1982.

On November 6, 1980, Commissioners William H. L. Woodyard III of Arkansas, Joseph C. Mike of Connecticut, Roger C. Day of Utah, and Susan M. Mitchell of Wisconsin were appointed to the Panel. Tera S. Younger, Director of the Bureau of Programs in the Health Care Financing Administration, is the designated representative of the Secretary and serves as the Panel's chairperson.

A determination by the Panel that a state program meets or exceeds the minimum standards means that all Medicare supplement policies sold in that state are deemed to meet the federal requirements and precludes policies issued in the state from review under the Federal Voluntary Certification program. However, a determination by the Panel that a state program has failed to adopt the minimum standards allows policies issued in the state to be submitted for consideration under the Federal Voluntary Certification Program, which is effective July 1, 1982. Under that program, the Secretary will review policies against the federal minimum standards. Those found to satisfy the standards would then be granted permission to bear a federal emblem, certifying their compliance with the minimum requirements established by section 1882.

The panel has reviewed the laws and regulations governing Medicare supplemental insurance in each state and the District of Columbia. These reviews were conducted in open meetings and each state was invited to speak on behalf of its own program. During our review, we voted to: render an advisory opinion on the program; approve the program; or approve the program subject to certain conditions.

Advisory opinions were rendered at the request of a state so it could determine where its program stood in comparison to the minimum standards, without having the Panel formally act on the regulatory program. Advisory opinions were also issued in instances where a state's regulatory program required an extensive overhaul to bring it into compliance and the state wished the Panel's guidance.

Programs approved by the Panel meet or exceed the federal minimum standards. A program approved conditionally by the Panel was one in which there was general compliance with the federal minimum standards, but some deficiencies existed, or complying legislation or regulations were prepared but were not yet in effect. States with conditionally approved programs were asked to modify their programs in a manner specified by the Panel to achieve compliance. Once the modification was accomplished the condition was removed and full approval was granted.

A state program was judged not expected to be in compliance with the standards only after the Panel had issued an advisory opinion or a conditional approval and the state had declined to make the changes necessary to achieve compliance.

Based on the results of these reviews, the Panel has determined that the programs of 45 states and jurisdictions are expected to meet the federal minimum standards by July 1, 1982. Ten are not expected to comply by July 1, 1982. The following table lists the status of each state program.

Of the 45 states the Panel expects to be in compliance by July 1, 1982, 22 require modifications to, or finalization of, their Medigap regulatory programs before they will fully comply. The Panel intends to conduct a continuing review of these states to monitor their progress and confirm their ultimate compliance. A continuing review of those states which are not now expected to have a program which meets the federal minimum requirements will also be conducted. This will enable the Panel to provide timely consideration to any state which may decide to adopt the minimum standards at some future date.

The Panel is pleased with the high number of states which have taken action to meet the minimum standards defined in section 1882. In general, the review of state programs has proceeded quite smoothly. However, during the course of our review, several technical issues surfaced which the Panel feels merit additional consideration. We will continue to study these issues and, if warranted, may prepare a report for your review at a future time.

I. States expected to meet the federal minimum standards by July 1, 1982.

A. States approved.

1. Alabama
2. Alaska
3. Arizona
4. Arkansas
5. Colorado
6. Florida
7. Georgia
8. Indiana
9. Iowa
10. Kansas
11. Mississippi
12. Montana
13. Nebraska
14. New Hampshire
15. North Carolina
16. North Dakota
17. Oregon
18. Tennessee
19. Texas
20. Utah
21. Vermont
22. Virginia
23. West Virginia

B. States conditionally approved or given advisory opinions which are expected to be in compliance by July 1, 1982. The Panel will continue to review the progress of these states to assure they finalize their programs or make the required modifications.

1. Connecticut
2. District of Columbia
3. Hawaii
4. Idaho
5. Illinois
6. Kentucky
7. Louisiana
8. Maine
9. Maryland
10. Michigan
11. Minnesota
12. Missouri
13. New Mexico
14. Nevada
15. Ohio
16. Oklahoma
17. South Carolina
18. South Dakota
19. Washington
20. Wisconsin

C. States from which the Panel has not received a formal submittal but are expected to be in compliance by July 1, 1982. The Panel will continue to review

the progress of these states to assure they finalize their programs.

1. Delaware
2. Puerto Rico

D. States from which the Panel has not received a submittal but are not expected to be in compliance by July 1, 1982.

1. New York
2. Guam
3. Virgin Islands
4. American Samoa

RESULTS OF REVIEW

The SHIP does not expect an approved program meeting or exceeding the minimum standards outlined in Title XVIII, Section 1882, of the Social Security Act to be in place by July 1, 1982, in the following states and territories.

1. California
2. Massachusetts
3. New Jersey
4. New York
5. Pennsylvania
6. Rhode Island
7. Wyoming
8. Guam
9. Virgin Islands
10. American Samoa

The basis for the Panel's determination concerning each of these states is as follows:

California

1. The Department of Insurance regulation governing commercial insurers and Blue Cross does not comply with the following sections of the NAIC model:

- *section 7I(2)*—the sale of catastrophic Medicare supplement policies which do not in every instance equal or exceed the model's minimum benefit requirements is allowed.
- *section 8K*—governing the format of the Outline of Coverage.
- *section 9*—concerning replacement requirements.

The Insurance Department has indicated a willingness to modify its regulation to achieve compliance except that the sale of catastrophic Medicare supplement policies will still be allowed.

2. The Department of Corporations' regulation governing Blue Shield does not comply with the following sections of the NAIC model.

- *sections 5G and 5H*—defining the terms "physician" and "nurse" respectively.

The Department of Corporations has indicated it will modify its regulation to comply.

Massachusetts

1. The Massachusetts program does not comply with the following sections of the Social Security Act:

- *section 1822(b)(1)(B)*—requiring that regulatory programs to be approved by

[1] Pennsylvania's regulation is effective September 20, 1982. The Panel recommends that the Federal Voluntary Certification Program not be implemented in Pennsylvania.

the Panel must require a 75 percent loss ratio for group Medicare supplement policies.

- *section 1822(b)(1)(C)*—requiring that regulatory programs approved by the Panel must regulate group as well as individual policies.

2. The Department of Insurance regulation does not comply with the following sections of the NAIC model:

- *section 7I(2)(a)*—requiring coverage of Part A eligible expenses for hospitalization to the extent not covered by Medicare from the 61st to 90th day of confinement in any Medicare benefit period.
- *section 7I(2)(c)*—requiring coverage of 90 percent of Part A expenses after exhaustion of the Medicare lifetime reserve days for a lifetime maximum of 365 additional days.
- *section 7I(2)(d)*—requiring that all Part B allowable expenses be covered subject to the satisfaction of a $200 out-of-pocket deductible.
- *section 8A(10)*—requiring the delivery of a Buyer's Guide.
- *section 8K*—governing the format of the Outline of Coverage.

The Department of Insurance has not indicated a willingness to seek compliance in any of the above noted areas.

New Jersey

1. The New Jersey program does not comply with section 1882(b)(1)(C) of the Social Security Act which requires that an approved regulatory program "provides for the application of the standards and requirements described in subparagraphs (A) and (B) to all Medicare supplement policies as defined in subsection (g)(1) issued in such state." The New Jersey program does not cover group policies and is not applied to Blue Cross and Blue Shield subscriber contracts.

2. The New Jersey program does not comply with the following sections of the NAIC model:

- *section 8A(10)*—requiring that a written receipt be provided when a Buyer's Guide is delivered.
- *section 8K*—governing the format of the Outline of Coverage.

The Department of Insurance has not indicated a willingness to seek compliance in any of the above noted areas.

New York

The Superintendent of Insurance for the State of New York in response to a request by the Panel that he provide a copy of the New York State regulation wrote:

> "any effort at this time to comply with your request would both frustrate what has been a most effective system of regulatory management in New York State and provide an inappropriate suggestion of legitimacy to your federal program."

Consequently, the Panel on its own obtained a copy of the New York regulations. The following deficiencies were noted:

1. The New York program does not comply with the following sections of the Social Security Act:

- *section 1882(b)(1)(B)*—requiring an approved program to maintain a loss ratio of at least 60 percent on all individual Medicare supplement policies.

• *section 1882(b)(1)(C)*—requiring approved states to regulate group as well as individual policies.

2. The New York regulation does not comply with the following sections of the NAIC model:

• *section 71(2)(d)*—requiring Medicare supplement policies to supplement Part B expenses whether incurred on an inpatient or an outpatient basis.

• *section 8A(10)*—concerning the delivery of the Buyer's Guide.

• *section 8B(1)*—requiring a written receipt for the outline of coverage.

Pennsylvania

1. The Pennsylvania program does not comply with section 1882(b)(1)(C) of the Social Security Act which requires that approved programs must regulate group as well as individual policies.

The Department of Insurance expects to be in compliance by July 1, 1982.

2. The Pennsylvania Statute requires that 365 days elapse between the date a regulation is promulgated and the date the regulation is effective. Consequently, the Pennsylvania Medigap regulation will not take effect until September 20, 1982.

The Panel believes Pennsylvania will be in full compliance on that date, and recommends that the Voluntary Certification Program not be implemented.

Rhode Island

State insurance regulation does not comply with the following sections of the Social Security Act:

• *section 1882(b)(1)(c)*—requiring that an approved regulatory program "provide for the application of the standards and requirements described in subparagraphs (A) and (B) to all Medicare supplemental policies, as defined in subsection (g)(1), issued in such state." The regulation distinguishes between "individual health benefit contracts" and "group and blanket health benefit contracts." It states "the standard provisions required for individual health benefit contracts shall not apply to group health benefit contracts."

• *section 1882(c)(2)*—requiring a 75 percent loss ratio requirement for group policies. A Rhode Island Department memo sets the loss ratio requirement for all Medicare supplements at 60 percent.

2. State insurance regulation does not comply with the following sections of the NAIC model:

• *section 5A,B,C,D,E,G,H,L and sections 7I(1)(b) and 7I(1)(c)*—providing the prescribed policy definitions. "Medicare eligible expenses" and "benefit period" are not defined in the regulation and the other terms are defined only for individual health benefit contracts.

• *section 6H*—prohibiting the use of the terms "Medicare supplement," "Medigap" and other words of similar import in policies which do not meet the minimum standards.

• *section 7I*—requiring a policy or combination of policies to cover both Part A and Part B minimums.

• *section 7I(1)(f)*—requiring that policies must automatically adjust benefits to coincide with changes in the Medicare cost-sharing amounts.

• *section 7I(2)(a)*—requiring coverage of Part A hospital coinsurance during

the 61st through the 90th day in any Medicare benefit period.

- *section 7I(2)(b)*—requiring coverage of Part A hospital coinsurance during lifetime reserve days.
- *section 7I(2)(c)*—requiring coverage of 90 percent of Part A expenses after exhaustion of Medicare lifetime reserve days to a lifetime maximum of 365 additional days.
- *section 7I(2)(d)*—requiring coverage of Part B expenses subject to a $200 out-of-pocket expenses deductible and a maximum benefit of at least $5,000 per calendar year.
- *section 8A(7)*—requiring a 30-day free-look provision for direct response policies.
- *section 8A(10)*—requiring delivery of a Buyer's Guide.
- *sections 8B(1),(2) and 8K*—concerning the Outline of Coverage requirements.

The Director of Business Regulation for Rhode Island has the authority to promulgate the more detailed regulations for Medicare supplements which would have moved the state toward compliance. However, he has indicated to the Panel that at this time he does not choose to do so.

Wyoming

The Wyoming program does not comply with the following sections of the NAIC model:

- *section 7I*—which requires that a policy or combination of policies cover both Part A and Part B minimums.
- *section 7I(2)(c)*—requiring that insurers must pay benefits for Medicare eligible expenses on the basis of the same or less restrictive conditions than Medicare.

The Department of Insurance has not indicated that it will comply with either of these requirements.

Guam

Guam has not submitted a program for review.

Virgin Islands

The Virgin Islands has not submitted a program for review although some interest has been expressed by the Department of Insurance.

American Samoa

American Samoa did not submit a program. The Acting Commissioner of Insurance noted that in light of the health care delivery system existent in the Islands there was very little call for Medicare supplement insurance. However, he indicated that this issue would be taken under advisement.

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